East Lancashire Hospitals NHS
NHS Trust

Quality Account

2015 | 16

Safe | Personal | Effective

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contents

PART ONE | INTRODUCTION TO OUR QUALITY ACCOUNT

1.1 Our Trust

East Lancashire Hospitals NHS Trust was established in 2003 and is an integrated Health Care Provider located in Lancashire in the heart of the North West of England. We provide high quality healthcare services primarily to the residents of East Lancashire and Blackburn with Darwen, which have a combined population in the region of 530,000.

- We employ 7,000 staff, some of whom are internationally renowned and have won awards for their work and achievements.
- We treat over 600,000 patients a year from the most serious of emergencies to planned operations and procedures.
- We offer care across five hospital sites, and various community sites, using state-of-the-art facilities.

We have a total of 996 beds:

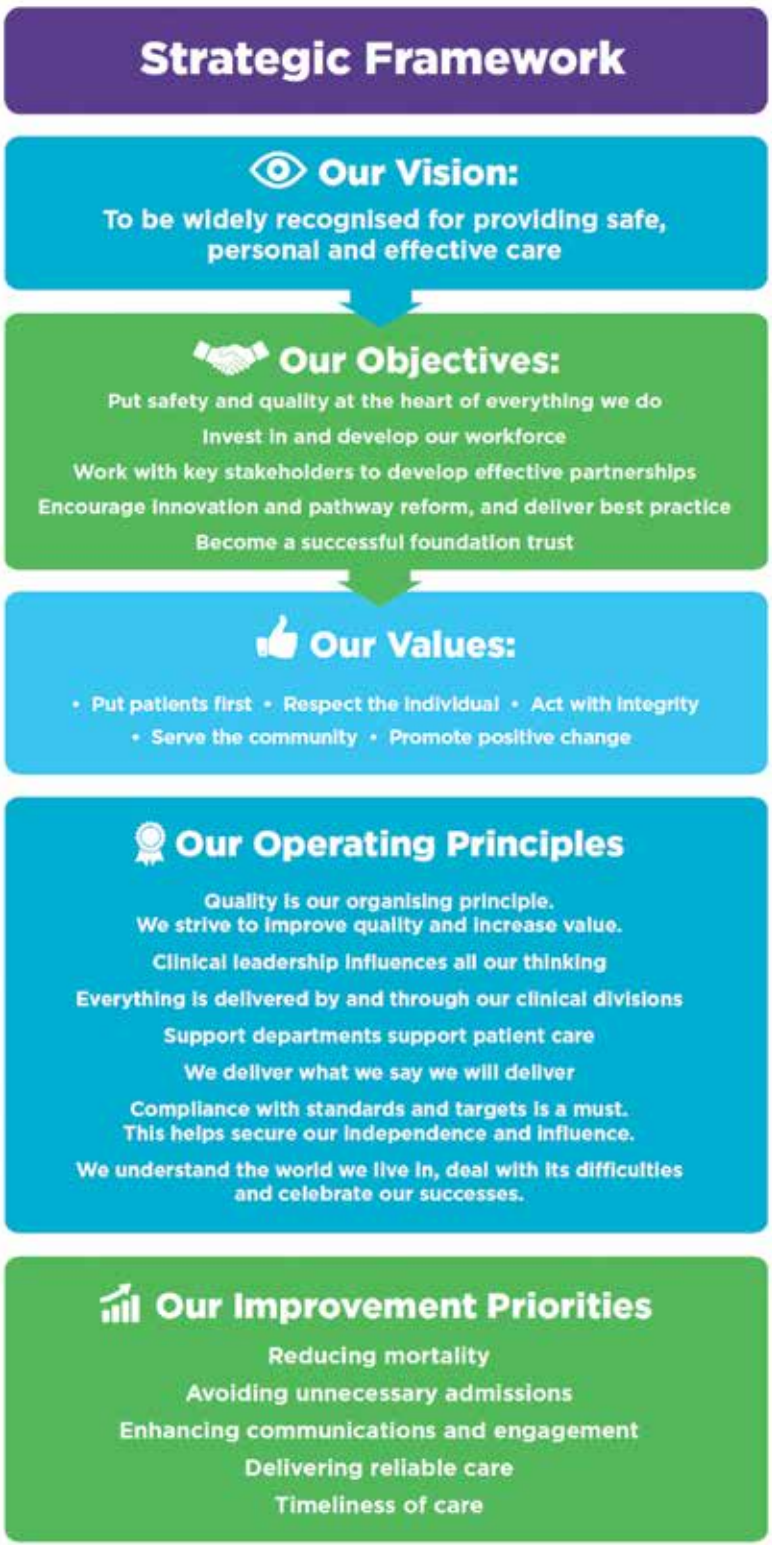
- 631 beds at the Royal Blackburn Hospital
- 241 beds at the Burnley General Hospital
- 33 community inpatient beds at Clitheroe Community Hospital
- 19 community inpatient beds at Accrington Victoria [Community] Hospital
- 72 community inpatient [beds at] Pendle Community Hospital

We provide a full range of acute hospital and adult community services. We are a specialist centre for hepatobiliary, head and neck, [vascular] and urological cancer services, in addition to providing specialist cardiology services and a network provider of Level 3 Neonatal Intensive Care.

1.2 Our Vision and Values

Our key commitment is to the delivery of the best possible healthcare services to the local population while ensuring the future viability of our services by continually improving the productivity and efficiency of services. This core focus has enabled demonstrable improvement in our key access, quality and performance indicators.

The strategic framework which guides all our activities is demonstrated in the diagram below:



1.3 Our Future

Over the next five years the Trust will see closer integration with providers of health and care across Pennine Lancashire through the Pennine Lancashire Transformation programmes, and across all Lancashire as part of Healthier Lancashire. We will seek greater roles in the provision of prevention of illness, in primary care, and in regional specialist work.

Across Pennine Lancashire, we will integrate more closely with providers in the primary, community, voluntary and third sectors. We will undertake co-design with commissioners, creating an "accountable care system" in Pennine Lancashire. Clinicians of the Trust will increasingly work with their professional colleagues from other providers to form Lancashire-based sustainable networks which determine the standards of care, the governance, and the delivery of care pathways.

Our Transformation themes will drive us towards a clinically and financially sustainable integrated organisation.

These themes are:

- Agreeing new system-governance principles with Healthier Lancashire and Pennine Lancashire Partners, agreeing key outcomes for the system
- Increasing primary and community care involvement: new models of care
- Increasing standardisation
- Improving efficiency in elective care
- Changing non-elective pathways
- Reviewing and networking specialist services.

We will achieve greater efficiencies, reducing length of stay for key medical conditions including COPD, reducing theatre times for elective and emergency surgery through increased productivity measures, and reducing our overall bed-base through the introduction of new pathways of care and integrated community care services.

We will continue to improve care in our Trust and community, increasing access to all relevant services across all seven days of the week, reducing avoidable mortality and improving patient experience.

1.4 Our Approach to Quality Improvement

The Trust is committed to the continuous improvement of the quality of care given to local people and, in so doing, achieve our organisational aim 'to be widely recognised for providing Safe, Personal and Effective Care'.

Quality monitoring occurs through our corporate and clinical governance structure, reporting to the Board via the Quality Committee. The Quality Committee is informed by the Patient Safety and Risk Assurance Committee, Clinical Effectiveness Committee, Serious Incidents Requiring Investigation Panel, Health and Safety Committee, Infection Control Committee, Internal Safeguarding Board and Patient Experience Committee. Divisional Directors or their agreed deputies, attend and report at these committees. Reporting in Divisions replicates this corporate structure to ensure consistent reporting from 'floor to Board'.

In order to ensure that we are delivering safe, personal and effective care we have a robust process for the identification and agreement of key quality priorities. Those that require quality improvement are consolidated into our Quality Improvement Plan including Harms Reduction Programme, Clinical Effectiveness (reliability) and Patient Experience, and monitored for progress through this structure.

Our Quality Improvement methodology is the 7 Steps to Safe Personal Effective Care. This is based on the Model for Improvement and also incorporates Lean and other tools. We have a small and developing quality improvement team of facilitators as part of the Quality and Safety Unit, linking with the Quality Committee structure. A staff development programme in quality improvement skills is in place both internally and through our membership of Advancing Quality Alliance (AQuA). Professionals in training are supported to develop and participate in quality improvement projects, and support for projects is agreed at the Quality Improvement Triage group.

Dr Damian Riley is Executive Medical Director and the lead for clinical quality.

The lead commissioner is East Lancashire Clinical Commissioning Group (CCG) accounting for approximately two thirds of activity undertaken by the Trust with Blackburn with Darwen CCG accounting for the major proportion of the remaining activity.

Relationships and communication with lead CCG's has been further strengthened during 2015/16. Monthly Quality Review Meetings are held chaired by the Commissioning Support Unit (CSU) with Quality Leads from all organisations. The focus of these meetings is around Clinical Effectiveness, Risk and Safety, Quality Improvement and the Patient and Family Experience. This communication is enhanced by weekly teleconferences between the lead CCG / CSU and the Trust.

The escalation process for incidents, risks and events of concern has been revised and improved to ensure timely and appropriate communication to all relevant parties.

Evidence is collated from Divisions and presented to one of the bi-monthly subcommittees of the Quality Committee and then to the Trust Board as below:

- Patient Safety and Risk Assurance Committee
- Clinical Effectiveness Committee
- Patient Experience Committee
- Health and Safety Committee
- Internal Safeguarding Board
- Infection Control Committee
- Serious Incidents Requiring Investigation Panel

Following the above meetings, validated reports and data are shared with CCG/CSU to provide assurance and to support Health Economy decision making. Reports include:

- Complaints
- Health Care Associated Infections (HCAI) report
- Exception reports against key performance standards

During 2015/16 a Quality Scorecard has been further developed to facilitate monitoring against a range of Quality Indicators.

1.5 Our Quality Account

Quality Accounts are annual reports from providers of NHS services which provide information about the quality of the services that they deliver. Our Quality Account demonstrates our commitment to continuous evidence-based service quality improvement and to explaining our progress in this area to patients, the public and interested parties.

The way in which we report through our Quality Account is set out in legislation and covers:

- The Trust's priorities for quality improvement for 2016/17
- Performance during the last year against quality priorities set by the Trust
- Performance during the last year against a range of nationally set quality indicators, initiatives and processes
- Performance during the last year against a range of other quality indicators, initiatives and processes

Our Quality Account has been developed over the course of 2015/16 as we have continually monitored and reported against our quality priorities and quality indicators both within the organisation and externally to the public, commissioners and regulators and at a national level. We have also invited a variety of representatives of local people to comment on what they think of this Quality Account and what it says about our Trust; their comments and contributions can be found in Part 3 of this report

We also want you to provide us with feedback about this report, or about the services we provide, and if you want to take up this opportunity please contact:

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1.6 Our Regulator's View of the Quality of Our Services

The Trust's latest Care Quality Commission (CQC) inspection was a follow up review conducted between 19th-21st October 2015 and looked at the four core services that had previously 'required improvement' (urgent care, medical care, surgery and end of life care) in order to review the progress of the Trust after coming out of special measures in July 2014. Our community sites were not inspected on this occasion but both the Royal Blackburn Hospital and Burnley General Hospital are now rated as 'good'.

The CQC inspection team looked at four core services rating them on being safe, effective, caring, responsive and well-led. Within Surgery on both hospital sites, the Trust received a rating of 'outstanding' in the category of well-led with the inspectors noting that "staff were energetic and motivated and were proud of the organisation as a place to work and visibility of leadership."

The inspectors also noted a number of positive key findings:

- The Trust had clear vision, objectives and values, operating principles and improvement priorities. All staff spoken to were dedicated to achieving the best care for their patients
- Hospital services were supported by strong governance processes ensuring a robust overview of risks within the hospitals
- The 'harm free care' strategy had improved the way the Trust dealt with and learnt from incidents and there was evidence that learning and change to practice from incidents was shared across services and trust wide.
- Cleanliness and hygiene was of a high standard
- Staff were kind and caring to patients and involved them in their own care
- Staff were proud of the work they did and supported each other. Though the last few years had been difficult, the stability of the current board and executive team had contributed greatly to the culture of continuous improvement.

The inspection in October 2015 was a focussed inspection as detailed above. The scores for each of the hospital sites inspected are shown below:

Burnley General Hospital Overall – Good

- Safe Good
- Effective Good
- Caring Good
- Responsive Good
- Well-led Good

Royal Blackburn Hospital Overall – Good

- Safe Good
- Effective Good
- Caring Good
- Responsive Good
- Well-led Good

An inspection of the well led key line of enquiry will be undertaken over the summer which may impact on the Trust's overall rating which is shown below:

East Lancashire Hospitals NHS Trust Overall – Requires improvement

- Safe Requires improvement
- Effective Good
- Caring Good
- Responsive Requires improvement
- Well-led Requires improvement

1.7 Our Chief Executive's Statement on Quality

I am very proud to present a Quality Account which demonstrates our organisation is one that has an intense focus at every level on delivering safe, personal and effective care to patients and learning from all possible sources how we can continually improve our care. I am humbled by the commitment demonstrated by all my colleagues, whether involved in delivering direct care or in supporting those that do, to meet the needs of patients in our local community and to work constructively with other organisations to make this a priority.

This year has seen some amazing progress in ensuring our patients' nutritional needs are met in hospital, avoiding sepsis, reducing harmful medication errors, assessing patients at risk from dangerous blood clots (VTE), maintaining a focus on reducing unexpected deaths and receiving positive feedback from our staff, patients and their families. We also acknowledge there are areas where we will need to continue our focus to maintain the progress that has been made and ensure further quality improvements, particularly in our Emergency Department and the way in which we ensure patients are assessed and prepared for their discharge. This has been reflected in the recent Care Quality Commission inspection findings rating both Royal Blackburn Hospital and Burnley General Hospital as good and I am particularly proud of the areas identified as having outstanding practice.

The areas we have identified for future improvement will receive particular focus in 2016/17 but we will continue to work to ensure our achievements to date are maintained and that every patient we care for and every family member or carer we interact with receives safe, personal and effective care, respecting the individuality of everyone.

To the best of my knowledge all the data and information presented in this 2015/16 Quality Account is true and accurate and the Quality Account has been approved by the Trust Board.

Kevin McGee
Chief Executive
East Lancashire Hospitals NHS Trust

PART TWO | QUALITY IMPROVEMENT

In this section of the report we outline the policies and strategies we have in place to ensure we continually monitor and report on the quality of our services (2.1 and 2.2) and what our priority areas for improvement in 2016/17 will be (2.3) . This part of the report concludes with information we, along with similar NHS providers, are required to publish about the quality of our services (2.4).

2.1 Our Strategic Approach To Quality

Our approach to quality is set out in our Quality Strategy (http://www.elht.nhs.uk/Downloads-docs/Corporate/2014/Quality%20Strategy_FINAL_April%202014_Web%20Version.pdf).

Delivering high quality care is the most important priority for the Trust. It is our vision to be widely recognised as a provider of safe, personal and effective care. The Quality Strategy describes the responsibilities of the Trust Board, senior leaders and all staff to ensure that safe, personal and effective care is given to all patients in a consistent and reliable way. In order to ensure the services we deliver meet the needs of our local population we work to improve our engagement with people at all levels in planning, delivering and developing services and ensuring ongoing evaluation of their effectiveness. We pride ourselves on making sure our staff are fully engaged in the planning and delivery of care and are very clear of the importance of staff delivering and receiving frank and honest feedback. We continually review our staff plans to help to ensure that we have a workforce capable of delivering safe, personal and effective care. We continue to work to ensure we have valid, reliable and meaningful information systems which allow real time measurement and evaluation of care delivery and have robust quality improvement programmes to ensure that there is a consistent approach to further improving the services we deliver.

Providing safe care means taking action to reduce harm to patients in our care and protecting the most vulnerable. It means caring for patients in a safe and clean environment using the right equipment. Our overall goal is to have no avoidable deaths and no avoidable patient harm. This means that we shall work to reduce the number of years lost from causes considered amenable to healthcare. Some groups of people are more vulnerable than others, and we shall focus closely on those who we know are more likely to be at risk from serious harm. We are committed to ensuring that patients and service users are cared for in surroundings which are safe and clean, delivered by caring and competent staff.

Providing care that is personal means ensuring that the services we provide are person-centred and that people are treated as individuals with dignity, in privacy and with compassion at the right time and in the right place for them. We are committed to enhancing the quality of life for all patient groups and to understand the importance of providing an environment where patients and their carers feel supported in dealing with their condition. We also understand that patients who suffer from long-term conditions are best cared for in a familiar and comfortable environment; to that end, we aim to reduce the amount of unnecessary time spent in hospital for people with chronic illness. In addition, the Trust focuses on improving the care delivered to patients with mental illness and dementia by fostering a culture where best practice can take root. We understand that the experience of healthcare for service users is dependent on the relationships they foster with health professionals. Part of providing a high quality service ensures that service users have trust and confidence in us and that they experience kind, compassionate and competent care and treatment.

Providing effective care means providing care that is based upon the best evidence and that produces the best outcomes for patients. It means fostering a culture of constant improvement by evaluating the quality and effectiveness of our services on a routine basis. It means ensuring that our workforce receives the right education and training in preparation for the delivery of competent and skilful intervention. We work to ensure that care delivered to patients occurs within the timescales shown to be most effective and is based upon the best evidence available.

2.2 Quality Monitoring And Assurance

To support delivery of our quality improvement work streams, the Trust has defined a meeting structure that supports the flow of information to and from the Trust Board. The corporate meeting structure is reflected within each of the Trust's clinical divisions thereby ensuring the Board has proper oversight of performance at all levels of the Trust, down to ward level. The meeting structure also provides a clear route of escalation for issues that need executive decision. Meetings take place on a regular basis and utilise standardised information to drive and inform the discussion. The data contained within the various performance dashboards showing monitoring of quality improvement areas is a mixture of outcome targets and process milestones that are presented to demonstrate performance at all levels of the Trust.

The Board Assurance Framework (BAF) and the Corporate Risk Register provide assurance to the Board that risks to patient safety, reputation and quality are appropriately managed in a timely way. The risk management processes are designed to ensure that current and potential future risks to quality are identified and included on the risk register, for example new technologies, changes in policy and funding. There are clear directorate and divisional reporting structures with specific triggers and processes by which risk and mitigating actions are reported and escalated. There is a clear and dynamic process for the management of risk in the organisation and both the BAF and the Risk Register are regularly reviewed to ensure that appropriate preventative and corrective actions have been taken.

The Trust Board is ultimately accountable for the delivery of quality outcomes and they are held to account by our regulators. Oversight of the Quality and Safety Framework is supported by a Quality and Safety Support Unit, comprising three specific portfolios of patient safety/clinical risk, patient experience and clinical effectiveness which includes the Quality Improvement Team. Similarly, Divisional Directors and Divisional General Managers are responsible for the delivery of quality outcomes within their divisions and the Trust Board holds the Divisional Senior Management Teams to account for delivering quality outcomes within their respective divisions. This principle of accountability and responsibility are reflected from Board to Floor and support the delivery of our quality objectives.

A robust Quality Impact Risk Assessment (QIRA) process is in place to ensure that our Safely Releasing Costs Programme (SRCP) ensures we continue to maintain Safe, Personal and Effective care as we work to reduce our cost base. The Medical Director and Director of Nursing are required to sign off every QIRA. The QIRA assesses the risk associated with each SRCP scheme and is embedded into the Trust's risk management processes. Through these processes high risk schemes are added to risk registers and are monitored through the processes described above.
During 2014-15 the East Lancashire Hospitals NHS Trust provided and/ or sub-contracted eight NHS services. These services have been identified using the Care Quality Commission's definition of regulated activities. The services provided during the year were:

- Treatment of disease, disorder or injury
- Diagnostic and screening procedures
- Family planning services
- Maternity and midwifery services
- Nursing care
- Surgical procedures
- Termination of pregnancies
- Management of supply of blood and blood-derived product

The Trust has reviewed all the data available on the quality of care in each of these NHS services. The Trust uses its integrated quality, safety and performance scorecard to facilitate this. Reports to the Trust Board, the Quality Committee, Patient Experience Committee, Clinical Effectiveness Committee, Patient Safety and Risk Assurance Committee and Operational Delivery Board all include data and information relating to quality of services. Progress against last year's priorities for quality improvement as set out in our Quality Account 2014-15 has been managed by way of these reporting functions.

The income generated by the NHS services reviewed in 2015-16 represents 94.1% of the total income generated from the provision of NHS services by the East Lancashire Hospitals NHS Trust for 2015-16.

2.3 Priorities For Quality Improvement 2016/17

Our Trust co-ordinates a comprehensive rolling program of quality improvement initiatives and our Quality Account serves to highlight a number of those initiatives which we will focus on specifically during 2016-17.

These quality improvement initiatives are as follows:

Subject	Quality aim	How the quality priority achievement will be measured	How the quality priority achievement will be monitored
Deteriorating patient	Implementation of a Trust wide approach to improve the recognition and the response to the deteriorating patient	Mortality / Cardiac Arrest / Deteriorating Patient score card	Monthly Deteriorating Patient Steering Group reports to bi-monthly Patient Safety Risk Assurance Group
End of life care	Optimise learning from complaints to improve end of life care	Monitor the number of complaints related to end of life care as a proportion of total complaints. Collate evidence of the learning from complaints to improve end of life care.	Regular assurance report to the End of Life Care Strategy Group
Hand hygiene	Increase compliance with hand hygiene and infection prevention guidance through "Prompt to Protect" improvement package	Achievement will be measured by way of mystery shopper hand hygiene audits, ward hand hygiene audits, environment audits, NAPF audits	Regular reports to the Infection Prevention Committee

2.4 Mandated Statements on the Quality of our Services

The Trust is required to include outcome information with its Quality Account on a range of quality focussed functions and these are set out below.

2.4.1 Clinical Audit and Confidential Enquiries

Clinical Audit involves improving the quality of patient care by reviewing current practice and modifying it where necessary. The Trust takes part in Regional and National Clinical Audits, and also carries out local audits. Sometimes there are also National Confidential Enquiries which investigate an area of health care and recommend ways of improving it. The Trust also takes part in these Confidential Enquiries.

During 2015-16 43 national clinical audits and 8 national confidential enquiries covered services that East Lancashire Hospitals NHS Trust provides. During that period East Lancashire Hospitals NHS Trust participated in 88% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that East Lancashire Hospitals NHS Trust was eligible for, and subsequently participated in are set out in the table below. The National Clinical Audits and National Confidential Enquiries that East Lancashire Hospitals NHS Trust participated in, and for which data collection was completed during 2015-16 also appears in the table below alongside the number of cases submitted to each audit or enquiry as a percentage of the number or the registered cases required by the terms of that audit or enquiry.

National Audits

Audit Topic	Coordinator	Frequency	Participation	Required Sample Submission
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	NICOR	Continuous	Yes	100%
Audit on Management of Invasive Cervical Cancer as part of National NHSCSP Cancer Audit	NHSCSP	Continuous	Yes	100%
BHIVA National Audit Programme ;audit of routine monitoring of adults living with HIV	BHIVA	Intermittent	Yes	100%
Bowel cancer (NBOCAP)	RCS	Continuous	Yes	100%
British Association of Endocrine and Thyroid Surgeons National Audit	BAETS	Continuous	No	100%
Cardiac Rhythm Management (CRM)	NICOR	Continuous	Yes	100%
Care of dying in hospital (NCDAH)	RCP	Intermittent	Yes	100%
Case Mix Programme (CMP)	ICNARC	Continuous	Yes	100%
Coronary Angioplasty/National Audit of PCI	NICOR	Continuous	Yes	100%
Diabetes (Paediatric) (NPDA)	RCPCH	Intermittent	Yes	100%
Emergency Use of Oxygen	BTS	Intermittent	Yes	100%
FFFAP: National FLDB Facilities Audit 2016	RCP	Continuous	Yes	100%
FFFAP: National Hip Fracture Database	RCP	Continuous	Yes	100%
Inflammatory Bowel Disease (IBD) programme	RCP	Continuous	Yes	100%
Lung cancer (NLCA)	RCP	Continuous	Yes	100%
Major Trauma: The Trauma Audit & Research Network (TARN)	TARN	Continuous	Yes	100%
National Audit of Intermediate Care	NHS Benchmarking Network	Intermittent	Yes	100%
National Cardiac Arrest Audit (NCAA)	ICNARC	Continuous	Yes	100%
National Complicated Diverticulitis Audit (CAD)	YSRC	Intermittent	No	100%
National COPD Audit Programme: Pulmonary Rehab	TCP	Intermittent	Yes	100%
National COPD Audit Programme: Secondary Care	RCP	Intermittent	Yes	100%
National Diabetes Adults	NHSCIC	Intermittent	Yes	100%
National Diabetes Footcare Audit	NHSCIC	Intermittent	No	100%
National Diabetes Inpatient Audit	NHSCIC	Intermittent	Yes	100%
National Emergency Laparotomy Audit (NELA)	RCA	Continuous	Yes	100%
National Heart Failure Audit	NICOR	Continuous	Yes	100%
National Joint Registry (NJR)	HQIP	Continuous	Yes	100%
National Ophthalmology Audit	RCOphth	Continuous	No	100%
National Per-operative Anaphylaxis Audit (NAP6) (1 Year Audit)	RCOA	Intermittent	Yes	100%

Audit Topic	Coordinator	Frequency	Participation	Required Sample Submission
National Pregnancy in Diabetes Audit	NHSCIC	Intermittent	Yes	100%
National Prostate Cancer Audit	RCS CSU	Continuous	Yes	100%
National Vascular Registry	RCS	Continuous	Yes	100%
Neonatal Intensive and Special Care (NNAP)	RCPCH	Continuous	Yes	100%
Nephrectomies	BAUS	Continuous	Yes	100%
NHSBT: 2015 Audit of Patient Blood Management in Scheduled Surgery	NHSBT	Intermittent	Yes	100%
NHSBT: 2015 Audit of the use of Blood in Lower GI bleeding	NHSBT	Intermittent	Yes	100%
NHSBT: 2016 Audit of the use of Blood in Haematology	NHSBT	Intermittent	Yes	100%
Oesophago-gastric cancer (NAOGC)	RCS	Continuous	Yes	100%
Paediatric Asthma	BTS	Intermittent	Yes	100%
Procedural Sedation in Adults (care in emergency departments)	CEM	Intermittent	Yes	100%
Rheumatoid and Early Inflammatory Arthritis	BSR	Intermittent	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	RCP	Continuous	Yes	100%
UK Parkinson's Audit (previously known as National Parkinson's Audit)	Parkinson's UK	Intermittent	No	100%
Vital signs in Children (care in emergency departments)	CEM	Intermittent	Yes	100%

Key to Audit Coordinator abbreviations	
BAETS	British Association of Endocrine and Thyroid Surgeons
BAUS	British Association of Urological Surgeons
BHIVA	British HIV Association
BSR	British Society for Rheumatology
BTS	British Thoracic Society
CEM	College of Emergency Medicine
COPD	Chronic Obstructive Pulmonary Disorder
FFFAP	Falls and Fragility Fractures Audit Programme
FLDB	Fracture Liaison Database
HQIP	Health Quality Improvement Partnership
HSCIC	Health & Social Care Information Centre
ICNARC	Intensive Care Audit & Research Centre
MINAP	Myocardial Infarction National Audit Project
NAOGC	National Audit of Oesophago-Gastric Cancer
NAP	National Audit Project
NBOCAP	National Bowel Cancer Audit Project

Key to Audit Coordinator abbreviations	
NCDAH	National Care of the Dying in Acute Hospitals
NCR	National Research Collaborative
NHSBT	NHS Blood & Transplant
NHSCSP	NHS Cervical Screening Programme
NICOR	National Institute for Cardiovascular Outcomes Research
NNAP	Neonatal National Audit Programme
NPDA	National Paediatric Diabetes Audit
PCI	Percutaneous Coronary Intervention
RCA	Royal College of Anaesthetists
	Royal College of Ophthalmologists
RCP	Royal College of Physicians
RCPCH	Royal College of Paediatrics and Child Health
RCPsych	Royal College of Psychiatry
RCS	Royal College of Surgeons
RCS CEU	Royal College of Surgeons Clinical Effectiveness Unit

National Confidential Enquiries

Audit Title	Coordinator	Frequency	ELHT Participated	Data collection completed 2015-16	Required Sample Submission
Child Health Clinical Outcome Review Programme: Adolescent Mental Health	NCEPOD	Intermittent	Yes	On-going	100%
Elective surgery (National PROMs Programme)	HSCIC	Continuous	Yes	On-going	100%
MBRRACE-UK: Perinatal Mortality	NPEU	Continuous	Yes	On-going	100%
MBRRACE-UK: Still Births and Infant deaths	NPEU	Continuous	Yes	On-going	100%
NCEPOD: Sepsis	NCEPOD	Intermittent	Yes	Yes	100%
NCEPOD: Gastrointestinal Haemorrhage	NCEPOD	Intermittent	Yes	Yes	100%
NCEPOD: Acute Pancreatitis	NCEPOD	Intermittent	Yes	Yes	100%
NCEPOD: Mental Health in Acute Hospitals	NCEPOD	Intermittent	Yes	On-going	100%

Key to Audit Enquiry Coordinator abbreviations	
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
PROMS	Patient Recorded Outcome Measures
MBRRACE-UK	Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries – United Kingdom
NPEU	National Perinatal Epidemiology Unit

The final or interim reports of 27 National Clinical Audits were received and reviewed by the East Lancashire Hospitals NHS Trust in 2015-16.

Of the 17 intermittent audits participated in, 7 National Clinical Audit reports have been reviewed by the Trust, 7 are awaiting reports or review and data collection is on-going for 3 audits. Of the 24 continuous audits; 20 reports have been received and reviewed in 2015-16, 1 is awaiting report and 1 new audit project. Annual and quarterly reports are reviewed at Audit or Multi-Disciplinary Team meetings / relevant forums and committees for discussion and action where identified.

Following the review of National Clinical Audit reports, East Lancashire Hospitals NHS Trust intends to continue to implement the following actions to improve the quality of healthcare provided:

- All audit activity is to be presented at specialty/ multi-specialty audit or other appropriate forums. It is at these meetings that recommendations and action plans will be decided so that practice and quality of care can be improved. These action plans will form part of the Clinical Audit annual report which will be presented to the Clinical Effectiveness Committee for on-going assurance and monitoring.
- We are also working collaboratively with East Lancashire CCG and associated commissioners to use audits to ensure that key patient safety and quality aims that are aligned to the CQUIN are reviewed and reported in order to set revised aims for 2016-17.

298 local clinical audits were completed by East Lancashire Hospitals NHS Trust in 2015-16. The results of which were presented / scheduled to be presented at specialty/ multi-specialty audit or other appropriate forums and the Trust intends to take the following actions to improve the quality of healthcare provided:

- All audits are presented and discussed at specialty/multi-specialty audit meetings and/or appropriate forums where action plans are agreed

- Lessons learned are included in audit meeting discussions alongside any actions required and captured for sharing
- Monitoring of action matrices occurs at subsequent audit or designated meetings to ensure that actions are implemented to agreed timescales led by the Specialty Audit Lead
- All specialty audit meeting minutes and action matrices will be reviewed at Divisional / Directorate Quality / Effectiveness meetings with assurance provision of effective care being monitored through divisional and corporate reporting at the Trust Clinical Effectiveness Committee
- Compliance with the Trust Policy on undertaking Clinical Audit Activity will be audited and reported at the Trust's Clinical Effectiveness Committee
- We will collate all Clinical Audit activity into an annual report as a record of all activity and actions undertaken and lessons learned as a result of audit to improve quality and patient care. This report will be received by the Trust Clinical Effectiveness Committee

2.4.2 Research and Development

The number of patients receiving NHS services provided or sub-contracted by the Trust during 2015-16 that were recruited during that period to participate in research approved by a research ethics committee was 1503.

2.4.3 Commissioning for Quality and Innovation (CQUIN)

A proportion of East Lancashire Hospital NHS Trust's income in 2014-15 was conditional on achieving quality improvement and innovation goals agreed between East Lancashire Hospitals NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. The goals were a combination of national and local Commissioner agreed CQUIN schemes. Further details of the national goals for 2015-16 and for the following 12 month period are available electronically on the NHS England website (https://www.england.nhs.uk/wp-content/uploads/2015/03/9-cquin-guid-2015-16.pdf).

The following table sets out brief details of the Trust's CQUIN scheme for 2015-1

Goal Number	Scheme	National/ Local	Description
1	Acute Kidney Injury	National	Achievement of the Care Bundle
2	Sepsis Screening	National	Achievement of the Care Bundle
3	Sepsis Antibiotic Administration	National	Achievement of timely intravenous antibiotics in cases of severe sepsis
4	Dementia and Delirium - Find, Access, Investigate, Refer and Inform (FARI)	National	Achieve 90% against the 3 national dementia assessment standards. Regular audit of carers of people with dementia. Delivery on agreed training programme.
5	Staff Training	National	To ensure that appropriate dementia training is available to staff through locally determined training programme.
6	Supporting Carers	National	Ensure carers of people with dementia and delirium feel adequately supported.
7	Reducing the proportion of avoidable emergency admission to hospital	National	Reducing the proportion of avoidable emergency admission to hospital
8	Improving recording of diagnosis in A&E	National	Improving recording of diagnosis in A&E
9	Discharge Communication	Local	Improve the quality of discharge summaries, ensuring a minimum dataset is utilized and that communication is timely.
10	Saving babies lives: Care bundle for reducing stillbirth and neonatal death	Local	Introduction of the Saving Babies Lives Care Bundles with an aim of reducing the avoidable stillbirth rate.
11	End of Life	Local	Bereavement survey conducted, results reported and action planned. Meeting staff needs - Establishing staff training and support requirements in relation to bereavement care
12	Cancer	Local	Redesign and implementation of referral pathways for 4 tumour sites
13	Women & Children	Specialised Commissioning	Neonatal critical care, reducing clinical variation and identifying service improvement requirements audits, questions identified
14		Specialised Commissioning	2 year outcomes for infants <30weeks gestation
15	Cancer	Specialised Commissioning	Eligible patients receiving a NICE GD 10 Compliant test
16	Blood & Infection	Specialised Commissioning	HIV reducing unnecessary CD4 monitoring
17	Clinically Managed Networks	Local Area Team	Contribute to supporting the Clinically Managed Networks in Orthodontics, Oral Surgery, Special Care Dentistry and Restorative Surgery.
18	Oral Surgery - Consistent Coding	Local Area Team	This indicator builds on the ground work of the implementation of consistent coding
19	Health Inequalities Action Plan Achievement	Local area team	Increase access and coverage of public health programmes across inequalities groups.

2.4.4 Care Quality Commission Compliance

East Lancashire Hospitals NHS Trust is required to register with the Care Quality Commission and its current registration status is unconditional.

The Care Quality Commission has not taken enforcement action against East Lancashire Hospitals NHS Trust during 2015-16.

East Lancashire Hospitals NHS Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

2.4.5 Data Quality Assurance

East Lancashire Hospitals NHS Trust submitted records during 2015-16 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.8% for admitted patient care
- 99.9% for outpatient care
- 99.1% for accident and emergency care

The percentage of records in the published data which included the patient's General Medical Practice Code was:

- 100% for admitted care
- 100% for outpatient care
- 100% for accident and emergency care

2.4.6 Information Quality and Records Management

The Trust's score for the reporting period, as a percentage, for Information Quality and Records Management, assessed using the Information Governance Toolkit published by the Audit Commission. East Lancashire Hospitals NHS Trust's score for 2015-16 for Information Quality and Records Management, assessed using the Information Governance Toolkit was 71%, which is considered as a satisfactory score.

2.4.7 Clinical Coding Audit

East Lancashire Hospitals NHS Trust was subject to the Payment by Results clinical coding audit during 2015-16 by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- HRG/Payment 96.6% accuracy – 3.4% error rate (net change in tariff of 1.2% - £3625)
- Primary Diagnosis (original error rate) 4% and Primary Diagnosis (all errors) 4%
- Secondary Diagnosis (original error rate) 2.3% and Secondary Diagnosis (all errors) 2.9%
- Primary Procedure (original error rate) 1.9% and Primary Procedure (all errors) 1.9%
- Secondary Procedure (original error rate) 8.34% and Secondary Procedure (All errors) 13.2

2.5 Complaints Management

As an organisation, feedback is a powerful and useful mechanism for improving the quality of care and the patient experience, both for individuals and for the wider NHS, as well as contributing to a culture of learning from experience. Patients, relatives and carers are encouraged to communicate any concerns to staff in a supported environment with the aim of addressing those concerns in a clear and concise manner. All staff are expected to try to resolve a patient or relative concern at the time of this being raised with them. We have adopted the principles of good complaints handling as set out by the Parliamentary and Health Service

- Ombudsman which are:
- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

The Trust Board acknowledges the importance of listening to patients' stories directly. As a result, patient stories are now regularly featured at Trust Board meetings in a range of formats (face to face, written, Microsoft Powerpoint).

A Complaints Review Panel is held quarterly. This panel is chaired by the Non-Executive Director who leads on complaints and is an in depth review of a randomly chosen complaint to ensure that a robust complaints process has resulted in a thorough and complete investigation, an open and honest response, appropriate action and monitored learning. The outcome of the meetings provides assurance to the Trust Board regarding the Trust Complaints Procedure and has led to improvements in the process.

In addition the Board receives weekly reports relating to new issues raised and a complaint is chosen randomly for regular presentation to the Executive Team. The complaint investigation, response and compliance with Trust Policy is assessed, in order that the process can be continually improved.

The Customer Relations Team is an integrated team of PALS/Complaints Officers, who deal with concerns raised formally and informally. The combined role ensures that individual concerns are addressed effectively and lessons are learnt from the issues raised. During 2015-16, 1286 PALS enquiries were dealt with by the team. These were received from a variety of sources. The team reports key performance indicators to Executive and Divisional leads to closely performance manage concerns raised and to ensure a timely response is provided. The Trust received 334 (41% reduction from 2014-15) formal complaints during this period. Complainants are contacted as soon as possible after raising their concerns.

The policy and procedure are currently under review and continual improvement and development will be maintained in 2016-17.

Further developments will continue to ensure that complainants are kept informed of the progress of the complaint investigation and for greater compassion within responses to complaints through education and formal training, and evidencing actions taken to improve services. Further training is planned for the coming year to raise awareness of staff responsibilities, Trust policy and NHS Complaints regulations, in addition to training on operational complaints handling. This will ensure that complaints are dealt with in a timely and appropriate manner.

The main issue for the Board is to receive assurance that lessons are learned from complaints, not only from an individual complaint, but across the Trust, where themes have been identified. During 2015-16, the Trust has developed the quarterly reports to include more detailed analysis on trends and themes, as well as lessons learned. The Trust has also continued to develop the Share 2 Care Bulletin to ensure that lessons learned from complaints and incidents are disseminated to all staff and learning is shared at a local level within wards and teams. This will be further developed in 2016-17 and mechanisms for sharing lessons learned will also be strengthened.

Complainants have the right to take their complaint to the Parliamentary and Health Service Ombudsman if they remain dissatisfied with the Trust's response. During the financial year, 13 complaints were referred to the Ombudsman, of which 2 were not upheld, 1 required further Trust action and 10 are currently being reviewed. No complaints from 2015-16 have so far been upheld

PART THREE | QUALITY ACHIEVEMENTS, STATUTORY STATEMENTS AND AUDITOR'S REPORT

3.1 Achievements Against Trust Quality Priorities

Duty of Candour

Duty of Candour is a statutory legal and contractual responsibility for NHS Trusts and ensures openness and honesty with patients or their families when things go wrong and patients are harmed as a result.

Duty of Candour directs that within 10 days of an incident that has resulted in moderate harm or above occurring, patients or their families should be:

- Notified of the incident
- Offered an apology
- Informed of the actions that are being taken to investigate
- Offered a letter outlining the discussion to date
-

The outcomes of any investigations should be shared thereafter with patients or their families and at East Lancashire Hospitals NHS Trust this is facilitated by way of a face to face meeting with relevant Trust staff in attendance.

During 2015-16 we have implemented a range of initiatives to help our staff comply with Duty of Candour including the delivery of bespoke training, simplified mechanisms for recording compliance, template letters and concise policy and procedures. We have also introduced a robust audit process whereby the Trust's Associate Medical Director is provided with a daily report which identifies any incidents where Duty of Candour may not have been completed fully within the 10 day timeline. The report also identifies those incidents where Duty of Candour has not been fully completed by day 6 of the timeline which in turn provides an opportunity for intervention at Divisional level.

The Duty of Candour process ensures that our patients receive comprehensive and timely information on what has gone wrong in the provision of their care and assurance on the actions that we will take to reduce the risk of the incident occurring again in the future.

Compliance with Duty of Candour across all divisions within the Trust is reported on a regular basis to the Patient Safety and Risk Assurance Committee and thereafter to the Quality Committee and the outcome of a recent review of Duty of Candour processes by the Trusts internal auditors has resulted in an opinion of "significant assurance".

Achievement against quality priorities set in 2014-15 for 2015-16

The table below sets out the quality priorities that the Trust identified for implementation during 2015-16 and the progress made:

No	Quality Priority Aim	How the quality priority achievement will be measured	How the quality priority achievement will be monitored	Achievement at year end
1	**Reduce the risk of malnutrition and dehydration through improvements in the assessment of patient's needs, access to and choice of food and increased support for patients at mealtimes**	Achievement will be measured by way of a risk and performance assessment framework which will include a ward level scorecard system	Regular report to the Trust's Nutrition and hydration Steering Group	• Electronic Malnutrition Screening Tool in use on all adult wards with the exception of Accrington Victoria who are using paper screening tools due to lack of Wi-Fi access. Work is on-going to improve and validate the reports on data from the electronic tool. • A revised Nutrition and Hydration care plan is in place to identify individual patients requirements. Audits of mealtime delivery included in the Nursing Assessment and Performance Framework (NAPF) and are showing improved scores on re-audit of wards. • Speech and language therapy are auditing the texture of the food provided against the national descriptions with good results, this has highlighted some areas for improvement such as consistent textures of custard. This is important for patients with dysphagia. • The Naso-gastric Tube Care Bundle has been piloted and rolled out across the Trust. Re-audit data is being collected to measure impact. • The Trusts first Food and Drink Strategy has been ratified and actions are in place to improve access to healthy, sustainable food and reduce waste across the Trust. • Incident reporting in regards to nutrition has been simplified with a review of the codes on the DATIX reporting system. Reports are not accessible and showed that 150 nutrition related incidents were reported in 2015/16, all of which were low harm. • Patient satisfaction in regards to food remains high with an average of 98% patients responding to the friends and family survey reporting satisfaction with food provision whilst in hospital.

No	Quality Priority Aim	How the quality priority achievement will be measured	How the quality priority achievement will be monitored	Achievement at year end
2	**Increase compliance with the sepsis care bundle to improve the recognition and timely management of severe sepsis and sepsis shock**	Achievement will be measured by way of assessment of compliance against the Advancing Quality sepsis target and national target CQUIN	Bi-monthly report performance report to the Patient Safety and Risk Assurance Committee	• Sepsis care bundle has been revised and education and training has taken place • Sepsis recognition and management has been promoted across the Trust in poster format and use of the intranet / Communications department • A revised and updated (in line with national guidance) clinical observation chart has been implemented across all adult admission and inpatient areas. • Collaborative working to raise awareness and improve systems and processes for identifying and managing patients with sepsis has been initiated
3	**Reduce medication incidents that cause moderate or more harm by 20%**	Achievement will be measured by way of a trajectory based upon the starting baseline position and the end point target	Bi-monthly performance report to the Patient Safety and Risk Assurance Committee	• At the end of the year the cumulative incidence of medication incidents causing harm was below the 20% reduction target. • Implementation of a new eLearning module for all Trust staff handling medicines to promote safe practice with medicines. • An improved reporting methodology for incidents relating to medicines that provides trend and point prevalence information for service areas. • Learning from incidents and observational audit of insulin prescribed has led to the establishment of an insulin safety group who are preparing a revised insulin prescribing and monitoring tool.

Sign up to Safety

It has been 12 months since the National Sign up to Safety campaign was launched at East Lancashire Hospitals NHS Trust. The campaign has involved the Trust developing and committing to a number of pledges to reduce avoidable harm and save more lives. The aims associated with these pledges are detailed below along with a summary of achievement and outcomes during the year.

Harm topic	Aim	Achievements	Outcomes
Falls	**Overarching Aim: T**o reduce the number of inpatient falls by 15% by August 2016 **Additional Aim:** To specifically reduce the number of inpatient falls (with harm) by 20% by August 2016	• Updated slips, trips and falls policy • Streamlined post falls protocol • New bed rails policy and risk assessment documentation • Plan / Do / Study / Act (PDSA) cycles of : – Communication aids – Bed & Chair sensors – Falls Leaf system – Slipper Socks – Bay tagging – Falls Medication Stickers • Falls link nurses identified • Improved communication with patient and carers in relation to the prevention of falls via updated patient information leaflets	• High risk patients treated on the most appropriate pathway • Improved patient care, experience and outcomes • Improved falls prevention awareness and education and training amongst staff • Increased falls prevention through patient empowerment • Right equipment used for patients at the right time • Reduced harm to patient's care in Hospital setting
	To improve the recognition of and response to the acutely deteriorating patient with a resultant decrease in unexpected cardiac arrests by 50%	• New processes to identify and respond to the deteriorating patient • New fluid balance policy • New patient project pack • ALERT training compliance • Early Warning Score process reviewed • Monthly Deteriorating Patient Faculty Meetings • Real time data via a ward score card to help identify and respond to deteriorating patients in a timely manner • Revised AKI (Acute Kidney Infection) Bundle • Information sharing and communication for AKI in the form of online resources and posters • Education review commenced regarding staff training for recognising the deteriorating patient	• At risk patients treated on the appropriate pathway • Patient deterioration recognised and treated sooner • Improve track and trigger compliance • Reduce mortality for emergency laparotomy patients • Improve education and training for staff to help identify deteriorating patients sooner

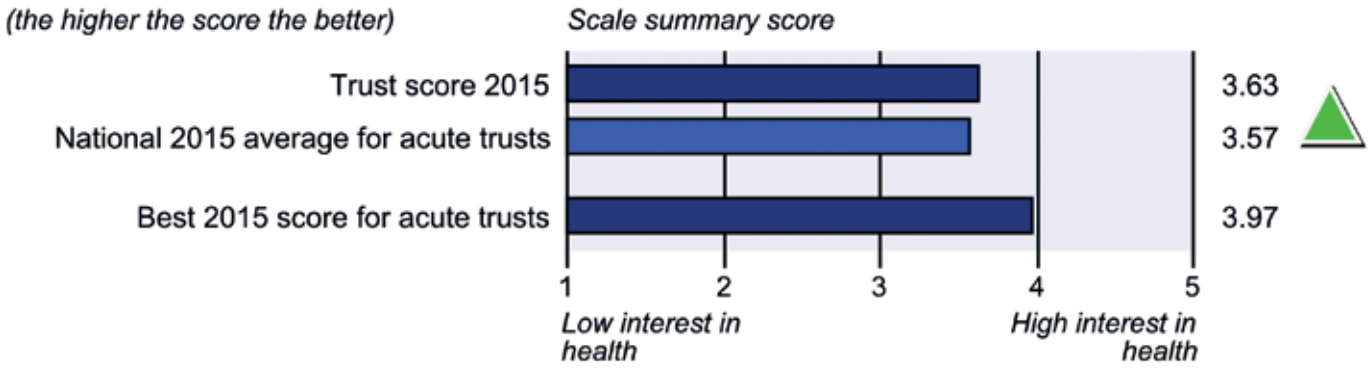
Harm topic	Aim	Achievements	Outcomes
Sepsis	To improve the recognition and subsequent timely management of sepsis in the emergency department and acute admissions unit	• Clinical champions identified for sepsis • Reconfiguration of the sepsis care bundle • Sepsis awareness campaign launched • Improved coding of sepsis episodes • Ward trials to improve the early identification of sepsis • Updating Early Warning Score (EWS) chart (adults only) rolled out across 5 sites for inpatients. • All areas currently redesigning their existing EWS pathways (booklets) • Collaborative working with community nurses (IHSS) to utilise the EWS in the community to help identify deteriorating patients in their homes	Improved patient outcomes through earlier detection and treatment of sepsis Improved staff awareness through education Improved experiences for patients and quality of life through proactive management of health needs Better multidisciplinary working, communication and reactiveness Improved responses to determining EWS
Surgical harm	To reduce avoidable surgical related patient harm incidents by 50%	• Staff champions in theatres • New measurement plan to track improvements • Safer surgery awareness sessions • WHO quality observation tool • Safety culture survey • Increased briefs and de-briefs in each theatre session • "Early Bird" project to help improve theatre start times/end times • Implementation of National Safety Standards for Invasive Procedures (NATSSIPS)	• Reduction in the number of surgical Never Events • Improved communication in theatres • Improved patient experience • Reduce harm to patients • Improve staff culture and communication in theatres • Improve staff culture and communication in theatres
Still births	To reduce stillbirth rate	• Improved detection and management of women at risk or with Foetal Growth Restriction (FGR) • Improved flow chart measurements • Growth scan training • Audit processes and measurement of FGR strengthened	• Babies lives saved through early detection of FGR • Improved staff awareness through education • Reduced anxiety for parents • Obstetricians and midwives trained to perform bedside scanning for growth

The designated leads for each of our Sign up to Safety aims will continue to work throughout 2016-17 to ensure we achieve our Sign up to Safety aims and further reduce avoidable harm to our patients.

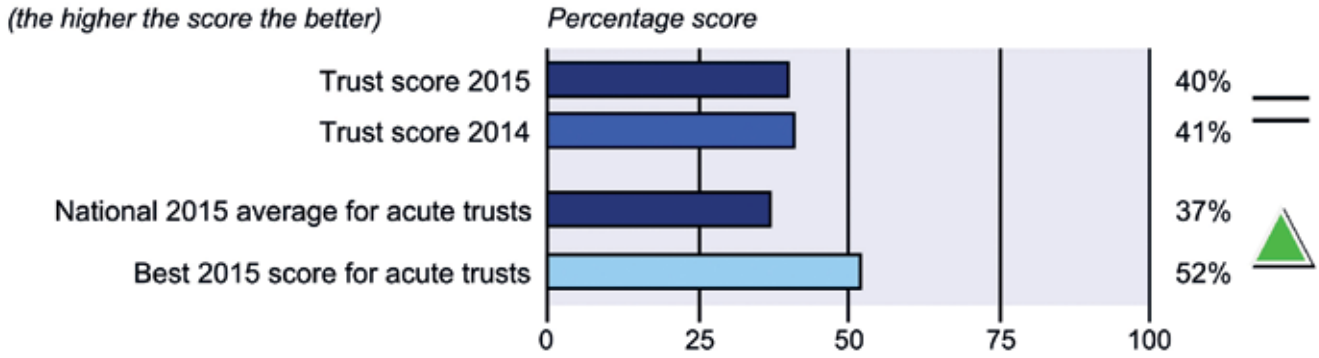
Staff survey results KF19 and KF27

The survey collects the experiences and opinions of NHS staff on a range of matters such as job satisfaction, wellbeing and raising concerns. The survey was carried out between September and December 2015 across 297 NHS organisations. Organisations can use the results to review and improve staff experience, which in turn can bolster improvements to patient care. The results also inform local and national assessments of the quality and safety of care, and how well organisations are delivering against the standards set out in the NHS Constitution. Obtaining feedback from staff, and taking account of their views and priorities, is vital for driving real service improvements in the NHS. Results from the NHS Staff Survey are presented for individual questions and for sub-groups of questions, combined to produce a number of "Key Findings" and an "overall engagement score". To ensure the data meets the needs of NHS organisations and associated bodies, the questionnaire, key findings and benchmarking groups have all undergone substantial revision since the previous staff survey. These changes mean that some questions and key findings are not comparable to 2014. Two key indicators from the national survey are provided below:

KEY FINDING 19. Organisation and management interest in and action on health and wellbeing



KEY FINDING 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse



3.2 Achievement Against National Quality Indicators

The Trust is required to provide data and information within its Quality Account on a range of nationally determined quality indicators. These are set out below:

3.2.1 Summary Hospital Level Mortality Indicator (SHMI)

The Summary Hospital-Level Mortality Indicator (SHMI) was introduced by the Department of Health in 2011-12 and reports on risk adjusted ratios of deaths that occur in hospital and up to thirty days after discharge, divided by the number of deaths that were expected given the size of the Trust and other factors such as the patient's age, method of admission and underlying medical conditions.

The published SHMI trend data up to September 2015 for East Lancashire Hospitals NHS Trust is set out in the following table:

SHMI Outcomes	Rolling 12 months to Sep 2015
East Lancashire NHS Trust SHMI Value	1.063
East Lancashire NHS Trust SHMI banding	2 (as expected)
National SHMI	100
Best performing Trust SHMI	0.652
Worst performing Trust SHMI	1.177

East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

- Our process requires that all deaths are subject to a primary mortality review, followed by a secondary review where appropriate.

East Lancashire Hospitals NHS Trust is taking the following actions to improve this ratio and so the quality of its services:

- Increasing awareness of mortality ratios across the Trust
- Improving reliability of care by introducing further care bundles and improving compliance rates
- Improving the current mortality review process, to ensure risks identified are investigated and key themes are identified and acted on
- Reducing health care acquired infections
- Improving the response to the deteriorating patient
- Alerting conditions are identified and subject to internal audit. Where cause is not identified, external review is requested.

In 2016-17 these actions will be consolidated and fully embedded within the Trust. This will be supported by the introduction of systematic audit and performance management.

3.2.2 Percentage of Patient Deaths With Palliative Care Coding

This is an indicator designed to accompany the Summary Hospital-level Mortality Indicator (SHMI). The SHMI makes no adjustments for palliative care. This is because there is considerable variation between Trusts in the coding of palliative care. Using the same data as the SHMI this indicator presents crude percentage rates of death that are coded with palliative care at either diagnosis or treatment specialty level.

East Lancashire Hospitals NHS Trust % of deaths with palliative care coding	20.6
Trust with highest % of deaths with palliative care coding	52.9
Trust with lowest % of deaths with palliative care coding	0

East Lancashire Hospitals NHS Trust considers that this data is described for the following reasons:

- Our process requires that all deaths are subject to a primary mortality review, followed by a secondary review where appropriate.

East Lancashire Hospitals NHS Trust is taking the following actions to improve this ratio and so the quality of its services:

- Increasing awareness of mortality ratios across the Trust
- Improving reliability of care by introducing further care bundles and improving compliance rates
- Improving the current mortality review process, to ensure risks identified are investigated and key themes are identified and acted on
- Reducing health care acquired infections
- Improving the response to the deteriorating patient
- Alerting conditions are identified and subject to internal audit. Where cause is not identified, external review is requested.

3.2.3 Patient Reported Outcome Measures

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient's perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys.

The four procedures are:

- hip replacements
- knee replacements
- groin hernia
- varicose veins

PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected pre-op and 6 months after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients; this data has been collected by all providers of NHS-funded care since April 2009.

The following tables set out the percentage of ELHT patients identified as achieving an 'improved post-operative adjusted average health gain' in comparison with the national figures for each of the 4 PROM's procedures using the EQ-5D measure of health gain. The 'EQ-5D Index' scores are a combination of five key criteria concerning patients' self-reported general health: mobility, self-care, usual activities, pain / discomfort and anxiety / depression).

Note: 2015–16 figures are provisional covering the period April to December 2015 (published on the 12th May 2016 by the HSCIC)

3.2.3.1 Groin Hernia Surgery

	2011-12	2012-13	2013-14	2014-15	2015-16
ELHT	47.8%	54.6%	48.6%	56.3%	52.5%
National average	51.0%	50.2%	50.5%	50.7%	50.8%

3.2.3.2 Varicose Vein Surgery

	2011-12	2012-13	2013-14	2014-15	2015-16
ELHT	39.1%	48.6%	59.1%	49.1%	59.6%
National average	53.6%	52.7%	51.9%	52.1%	53.9%

3.2.3.3 Hip Replacement Surgery

	2011-12	2012-13	2013-14	2014-15	2015-16
ELHT	89.5%	88.5%	87.4%	94.0%	93.9%
National average	87.5%	89.7%	89.4%	89.6%	90.1%

3.2.3.4 Knee Replacement Surgery

	2011-12	2012-13	2013-14	2014-15	2015-16
ELHT	79.4%	80.8%	78.60%	84.40%	82.6%
National average	78.8%	80.6%	81.40%	81.00%	82.2%

East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

1. ELHT has a process in place to ensure patients receive a pre-operative questionnaire at pre-assessment, the process is explained to the patient and completed questionnaires collated for submission .
2. Patients can decline to complete the questionnaire (optional); in these cases questionnaires are still collated to monitor ELHT submission rates and inform where education and patient information may be required.

East Lancashire Hospitals NHS Trust is taking the following action to improve performance, and so the quality of its services

1. A verbal request sheet has been scripted to ensure standardisation of information given to maintain and improve on participation rates
2. Ensuring the process at pre-assessment is checked on a weekly basis to maintain and improve on current figures where required
3. Random spot checks to be continued to prevent a decline in participation rates, feedback will be given on a weekly basis to the Pre-op Assessment Coordinator via email
4. If a questionnaire is not completed at pre-op assessment then SADU will aim to complete

NB: following a conversation with Ward 15. It is proposed that questionnaires could be given out at hip and knee school when this is established (June 2016). The Hip & Knee School is an educational session for patients to provide information around expectations on lifestyle improvements.

3.2.4 Readmissions Within 28 Days of Discharge

The following tables set out the Trust's performance during 2015-16 for emergency readmissions within twenty eight days of discharge. We have used Dr Foster data which provides national benchmarking from the National Hospital Episodes Statistics data. The HSCIC do not provide recent data on readmissions at the level of detail required.

All Ages	2012/2013	2013/2014	2014/2015	2015/16
Readmission Rate	8.71%	8.40%	8.74%	8.77%
Age Band	2012/2013	2013/2014	2014/2015	2015/16
0-15	12.06%	11.15%	11.21%	11.60%
16+	7.95%	7.80%	8.19%	8.14%

East Lancashire Hospitals NHS Trust considers the data is as described for the following reasons:

- Adult readmissions remain within expected range with little variance
- Paediatric readmissions are consistently higher and this may partly be as a result of the Trust's open access policy which ensures quality of care for families but impacts on readmission rates.

East Lancashire Hospitals NHS Trust is taking the following action to improve performance, and so the quality of its services:

- ***Family Care***
- Readmission rate audits continue to be undertaken by the division's Utilisation Management Team with all identified actions being implemented. This work has been led by the divisions nominated readmissions lead consultant.
- A health economy wide patient information leaflet which helps support parents in managing their children's key illnesses has been developed and launched.
- Coding of all relevant admissions continues to be reviewed to ensure accuracy of readmission data collected.
- A Community Paediatric Respiratory Team has been established to work alongside children and families and prevent readmissions.
- The Division continue to utilise the Children's Community Nursing Team Service.

- ***Integrated Care Group***
- The trust has implemented phase 1 of the Acute Medical Unit project, involving an increase in the capacity of the Acute Medical Unit and an investment into additional acute physicians. Associated with this model is a plan for increasing the utilisation of ambulatory care both for first attendance and also supporting safe early discharge.
- The Intensive Home Support Service has been fully launched and now provides an in-reach service to the Trust's Emergency Department and Acute Medical Unit. Patients are actively followed up on discharge from hospital, and this is expected to lead to reduction in the need for readmission. The Integrated Neighbourhood Teams are also now in place across Pennine Lancashire.
- The trust continues to work with social care and Clinical Commissioning Group colleagues to implement an Integrated Discharge Service

- ***Surgery***
- Plans are in place for the launch of a Hip and Knee School later in year. The focus of the school is to educate patients coming in for surgery to make them aware of potential side effect, so they do not re-present at A&E unnecessary. The school will see approx. 800 patients a year
- The Trust is involved in the National Clinical Quality and Efficiency Programme - Getting it Right First Time in Orthopaedics. This is a three year programme which aims at improving outcomes, delivering efficiencies and removing unwanted variations.
- A review of the Surgical Triage Unit (STU) has been undertaken to identify any gaps or blockages within current systems. Recommendation and improvements have been made to improve patient flow though the unit.

3.2.5 RESPONSIVENESS TO PERSONAL NEEDS OF PATIENTS

The Picker Institute was commissioned by 81 Trusts nationally to undertake the Inpatient Survey in 2015. A total of 1250 patients from East Lancashire Hospitals NHS Trust were sent a questionnaire. 1222 were eligible for the survey, of which 491 returned a completed questionnaire, giving a response rate of 40%. The response rate for the inpatient survey conducted in 2014 was 50%.

The table below sets out the Trust's performance in 2015 for inpatients:

The Trust has improved significantly on the following questions:

Lower scores are better

NONE

The Trust has worsened significantly on the following questions:

Lower scores are better

	2014	2015
Admission: had to wait long time to get to bed on ward	32 %	41 %
Overall: not asked to give views on quality of care	67 %	74 %
Overall: Did not receive any information explaining how to complain	57 %	65 %

Your results were significantly better than the 'Picker average' for the following questions:

Lower scores are better

	Trust	Average
Hospital: shared sleeping area with opposite sex	5 %	8 %
Hospital: patients using bath or shower area who shared it with opposite sex	5 %	12 %
Hospital: bothered by noise at night from other patients	33 %	39 %
Discharge: Staff did not discuss need for further health or social care services	12 %	17 %

Your results were significantly worse than the 'Picker average' for the following questions:

Lower scores are better

	Trust	Average
Admission: had to wait long time to get to bed on ward	41 %	32 %
Hospital: not offered a choice of food	28 %	20 %
Nurses: sometimes, rarely or never enough on duty	44 %	38 %
Care: wanted to be more involved in decisions	48 %	41 %
Care: staff did not do everything to help control pain	35 %	29 %
Discharge: delayed by 1 hour or more	90 %	85 %
Overall: not asked to give views on quality of care	74 %	69 %
Overall: Did not receive any information explaining how to complain	65 %	59 %

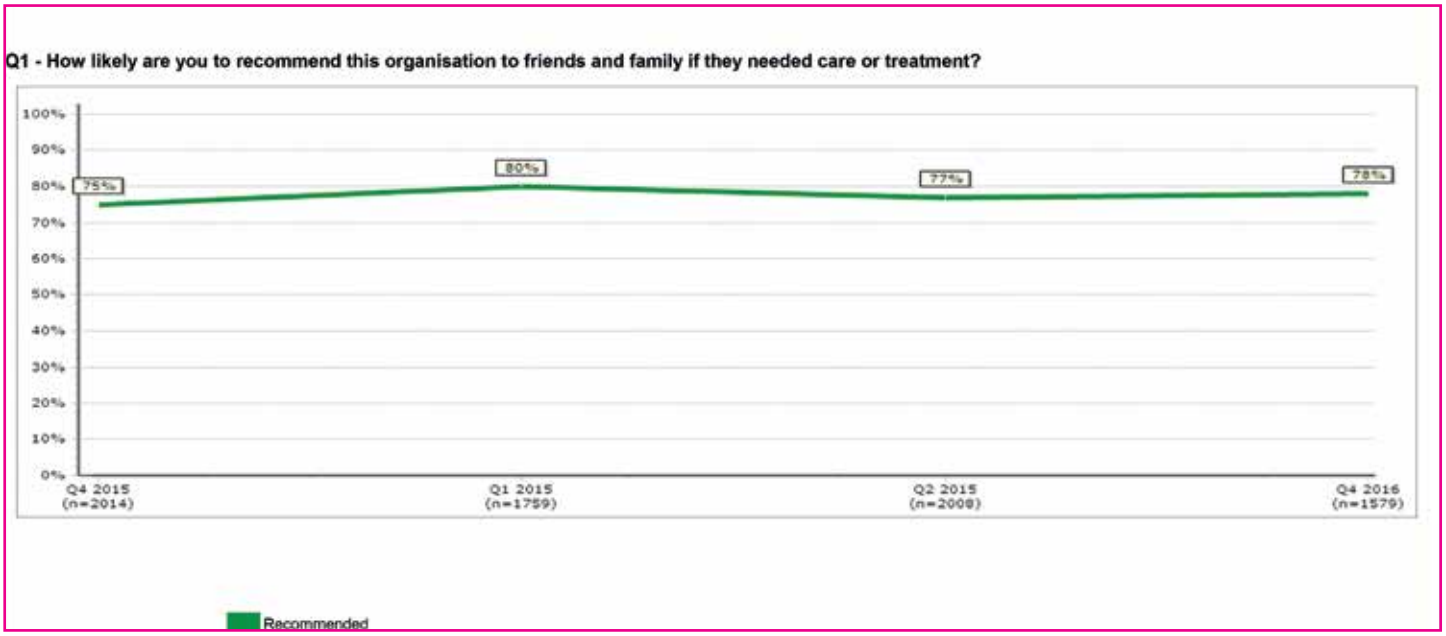
East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

- Continued effort is required to engage and listen to care experience of patients, their carers' and families and to respond to this feedback
- The sample this year showed an increase in the proportion of non-elective patients surveyed in comparison to previous years
- Continuing challenges around the increase in numbers of patients attending Emergency Departments and requiring admission.
- East Lancashire Hospitals NHS Trust is taking the following action to improve performance, and so the quality of its services:
- Investment in Estates and Facilities to improve ward environments
- Re-design of our Acute Medical Model to enable more patients to leave hospital within 72 hours with improved continuity of care whilst in the hospital, with greater support and continuing care once patients are discharged into the community.
- Supporting directed action plans across Divisions to improve the patient and carer experience
- Supporting major transformation which will improve our bed management, admission and discharge processes. Introduction of Ward Clinical Flow Co-ordinators to facilitate timely discharge
- Continuous Quality Improvement projects including:
  I. Future Hospitals Programme which aims to support the re-design of services for frail older people across the Care Continuum.
  II. The launch of our Food and Drink Strategy which details our aspirations in providing healthy, nutritious and sustainable food not only to patients but to visitors and staff also. Improvements include electronic forms to ensure everyone is screened for risk of Malnutrition; eating and drinking care plans to ensure patients can express their likes and dislikes and any assistance they may require; a trial of a new menu choice system on some wards that allows patients to choose their meal preference a meal in advance rather than the day before and snack boxes for those who are hungry outside of mealtimes.
- Review of staffing establishments and daily monitoring of safe staffing levels. The Trust has been successful in recruiting overseas nurses and holds regular recruitment open days.
- Continue to engage and work with our patients, their families and carers around our provision of services to maintain the quality delivered.
- Provision of information across Divisions regarding how to complain.

3.2.6 Recommendation From Staff as a Provider of Care

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends. This provides an indication of whether our staff feel the Trust provides a positive experience of care for our patients.

The Trust scored 3.8 in this area on the national survey in 2015, an improvement on the previous year score of 3.66. The national average for UK acute trusts for 2015 was 3.76 with the highest score in 2015 being 4.0.



Q1 - How likely are you to recommend this organisation to friends and family if they needed care or treatment?

	Q4 2015	Q1 2015	Q2 2015	Q4 2016	Total
Base	2014	1759	2008	1579	**7360**
Extremely likely	531	483	508	429	**1951**
	26%	27%	25%	27%	**27%**
Likely	976	916	1034	801	**3727**
	48%	52%	51%	51%	**51%**
Neither likely nor unlikely	336	250	316	235	**1137**
	17%	14%	16%	15%	**15%**
Unlikely	106	65	86	68	**325**
	5%	4%	4%	4%	**4%**
Extremely unlikely	39	31	44	31	**145**
	2%	2%	2%	2%	**2%**
Don't know	26	14	20	15	**75**
	1%	1%	1%	1%	**1%**

The East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

- Data is as received from NHS England and the Picker Institute and had been checked locally by the Staff Health Wellbeing & Engagement Department.

The East Lancashire Hospitals NHS Trust intends to take the following actions to improve this percentage, and so the quality of its services by,

- Continuing to embed the Employee Engagement Strategy to drive further improvements in staff experience and engagement.
- Continuing to complete focused work on the ten key enablers which have been identified to enhance levels of employee engagement together with the additional three behavioural indicators used to demonstrate high employee engagement levels.
- Continuing to promote, gather, analyse and action staff suggestions, involvement and feedback from employees within the organisation.
- Continuing to monitor and review our approach to employee engagement through our employee engagement sponsor group chaired by the Chief Executive, to ensure East Lancashire Hospitals NHS Trust is an exemplar of best practice for employee engagement in the UK.

3.2.7 Friends And Family Test Results in the Emergency Department

In April 2013, the Department of Health introduced the Friends and Family Test as a means to establish whether patients that have recently received care within acute hospital Trusts would be happy for their friends or relatives to receive similar care within the same environment.

The question that is asked is:

- How likely are you to recommend our service to your friends and family if they needed similar care or treatment?

Patients are invited to respond to the question by choosing one of six options ranging from extremely likely to extremely unlikely.

Currently inpatients, including surgical day case attenders, accident and emergency attenders, maternity, outpatient attenders and community service users are asked this question.

The following table sets out the East Lancashire Hospitals NHS Trust's response rates for inpatients, accident and emergency attenders and maternity services, and also how these results compare with other Trust's nationally for the period April 2015 to March 2016.

	April 2015	May 2015	June 2015	July 2015	August 2015	September 2015	October 2015	November 2015	December 2015	January 2016	February 2016	March 2016
Inpatient % patient response rate												
ELHT	51%	57%	60%	58%	55%	46%	49%	44%	50%	49%	49%	50%
National Average	26%	27%	27%	28%	26%	25%	25%	25%	23%	24%	25%	24%
A&E % patient response rate												
ELHT	24%	23%	26%	23%	25%	25%	25%	23%	24%	21%	22%	22%
National Average	15%	14%	15%	15%	14%	14%	14%	13%	13%	13%	13%	12%
Combined inpatient and A&E % patient response rate												
ELHT	34%	35%	37%	35%	36%	33%	34%	31%	34%	32%	32%	33%
National Average	Not Available											
Antenatal % patient response rate												
ELHT	16%	11%	11%	16%	8%	11%	26%	29%	28%	20%	45%	47%
National Average	*Not Available											
Delivery % patient response rate												
ELHT	29%	30%	37%	30%	41%	30%	35%	38%	24%	31%	43%	27%
National Average	24%	23%	24%	22%	21%	23%	22%	23%	21%	23%	25%	23%
Post Natal % patient response rate												
ELHT	50%	36%	40%	55%	33%	36%	28%	35%	22%	36%	32%	19%
National Average	*Not Available											
Community Post Natal % patient response rate												
ELHT	18%	16%	17%	21%	20%	16%	13%	18%	12%	11%	16%	14%
National Average	*Not Available											

* Feedback from maternity providers suggested that identifying an accurate eligible population for questions 1, 3 and 4 was complex and time-consuming. As a result, NHS England permitted providers to submit estimates for the eligible population data at questions 1, 3 and 4. As the eligible population figures submitted for these questions are estimates, NHS England does not publish a response rate for questions 1, 3 and 4. Response rates have only been published for question 2 as NHS England was confident that the eligible population figures submitted for question 2 were accurate (based on hospital birth records)."

The following table sets out the percentage of Inpatients, Accident & Emergency attenders, Maternity Service users and Outpatients who would recommend the service, and also how these compare with other Trust's nationally for the period April 2015 to March 2016.

	April 2015	May 2015	June 2015	July 2015	August 2015	September 2015	October 2015	November 2015	December 2015	January 2016	February 2016	March 2016
Inpatient % recommend												
ELHT	98%	98%	98%	99%	99%	99%	98%	98%	99%	99%	98%	98%
National Average	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%
A&E % recommend												
ELHT	77%	79%	83%	77%	84%	85%	83%	83%	85%	78%	80%	77%
National Average	88%	88%	88%	88%	88%	88%	87%	87%	87%	86%	85%	84%
Combined inpatient and A&E % recommend												
ELHT	89%	90%	91%	90%	92%	92%	91%	92%	93%	91%	91%	89%
National Average	Not Available											
Antenatal % recommend												
ELHT	98%	89%	100%	99%	92%	98%	97%	99%	98%	98%	99%	98%
National Average	95%	96%	96%	95%	95%	95%	95%	96%	95%	96%	95%	95%
Delivery % recommend												
ELHT	97%	97%	98%	96%	96%	94%	94%	96%	91%	98%	96%	96%
National Average	97%	97%	97%	97%	97%	97%	96%	96%	97%	97%	96%	96%
Post Natal % recommend												
ELHT	97%	95%	90%	96%	94%	97%	93%	97%	90%	95%	94%	100%
National Average	94%	93%	93%	94%	94%	93%	94%	94%	94%	94%	94%	94%
Community Post Natal % recommend												
ELHT	94%	90%	96%	91%	91%	92%	91%	91%	91%	93%	92%	93%
National Average	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Outpatient % recommend												
ELHT	96%	97%	97%	97%	100%	99%	95%	94%	95%	93%	93%	93%
National Average	92%	92%	92%	92%	92%	92%	92%	92%	92%	93%	93%	93%

The East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:
Our inpatient response rates regularly exceed the national average as we consider the collection of feedback from our patients to be a high priority, therefore staff are encouraged to collect information from patients.

Since the introduction of SMS text messaging the response rates for A&E attenders increased and are regularly above the national average.

The Trust also gets a consistently high score on the willingness to recommend the service.

The East Lancashire Hospitals NHS Trust intends to take the following actions to improve this percentage, and so the quality of its services, by the following actions:
Continue to regularly monitor the response rates and provide advice and support to specific areas so that information is collected and input in a timely manner. Going forward, the Friends and Family test continues to be introduced to other departments and services to promote a Trust wide view of patient services.

3.2.8 Venous Thromboembolism Assessments

The data made available to Trust by the Health and Social Care Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period. This provides an indication of how the Trust treats and cares for people in a safe environment and protects them from harm.

The table below sets out the Trust's VTE risk assessment performance against the national standard of >95%.

	VTE Assessments	15-16				
		Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
National	Number of VTE-assessed Admissions	3475078	3533672	3547721		10556471
	Total Admissions	3618305	3686398	3710703		11015406
	Percentage of admitted patients risk-assessed for VTE	96.04%	95.86%	95.61%		95.83%
ELHT	Number of VTE-assessed Admissions	29596	29322	29711	29822	118451
	Total Admissions	29762	29847	30041	30041	119691
	Percentage of admitted patients risk-assessed for VTE	99.44%	98.24%	98.90%	99.27%	98.96%
	Rank Position of ELHT / number of Acute Trusts	8/160	26/158	16/157		
	Best Performing Trust	2 Trusts with 100 %	4 Trusts with 100 %	4 Trusts with 100 %		
	Worst performing Trust	86.10%	75.00%	78.50%		

East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

- Systems and processes are in place for risk assessing all appropriate patients utilizing the National VTE assessment tool on admission. This involves both adult inpatient admissions and day cases.
- The Trust monitors quarterly VTE performance figures routinely using an electronic system with real time capture of data on admission from the Patient Administration System (PAS) and Electronic Patient Tracking System (EPTS).
- Each of the Trusts' Divisions participate in a rolling programme of clinical audit to ensure effective compliance with VTE assessment.
- The Trust's VTE performance has consistently been in excess of 98% since July 2015 and prior to that in excess of 97% since July 2013 and prior to that in excess of 95%.

East Lancashire Hospitals NHS Trust is taking the following action to improve performance, and so the quality of its services:

- Supporting matrons to carry out spot checks on VTE assessment compliance at ward level
- Continuing with a rolling programme of VTE assessment clinical audit across Divisions
- Supporting Divisional Governance leads to monitor the monthly VTE risk assessment figures for the Divisions and identify poor performing areas to focus remedial efforts through formal online reporting arrangements that enable this and monitored through the Trust VTE committee
- Enhancing the robustness of governance processes for completion of Root Cause Analysis (RCA) investigations on Hospital Acquired VTE's through an online RCA tool that is VTE specific and includes VTE risk assessment details which is approved through the Trust Serious Incidents Review group (SIRG) from January 2016

3.2.9 Clostridium Difficile Rates

The data made available to the Trust by the Health and Social Care Information Centre with regard to the rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.

	CDI rate cases per 100,000 bed days (for year to Nov 15)	CDI rate cases per 100,000 bed days (for year to Nov 14)	CDI rate cases per 100,000 bed days (for year to Nov 13)
National rate (Ordinary Acute Trusts)	15.52	13.1	14.9
ELHT rate	9.94	9.6	8.0
Best performing nationally	3.32	3.6	2.4
Worst performing nationally	39.99	43.8	37.5

East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

- Assertive action on management of hospital acquired infections has been undertaken for a number of years to reduce the rate to the present level. Each case both pre- and post- three days of admission is discussed at the C. difficile multidisciplinary CCG meeting to determine lapses in care.
- East Lancashire Hospitals NHS Trust intends to take actions to improve this rate and so the quality of its services by:
- Further improving compliance to hand hygiene, improving antimicrobial prescribing and continuing the post infection review process to enable any lapses in care across the Health Economy to be identified and rectified.
- Continuing with its current approach of zero tolerance to hospital acquired infections and will aim to further reduce this rate year on year and so improve the quality of its services and patient experience.

3.2.10 Patient Safety Incidents

NHS Trusts are required to submit the details of incidents that involve patients to the National Reporting and Learning System (NRLS) on a regular basis. The Trust continues to upload data via the NRLS on a monthly basis. The NRLS publishes Organisation Patient Safety Incident Reports bi-annually showing comparative data with other large acute organisations. The Trust is able to use this information to understand its reporting culture. High reporting Trusts usually have a strong safety culture and as such the Trust continues to actively encourage the reporting of incidents and near misses.

The information in the table below has been extracted from NRLS reports and sets out the Trust's performance for the last four reporting periods. The table also compares the Trust's performance against other similar large acute organisations (cluster).

Patient safety incidents per 100 admissions	April 2014 to Sept 2014	Oct 2014 to Mar 2015	April 2015 to Sept 2015
ELHT number reported	8190	7563	6732
ELHT reporting rate	55.7	48.2	44.18
Cluster average number	4196	5458	4647
Cluster average reporting rate	35.9	31.2	39
Minimum value for cluster	35	443	1559
Maximum value for cluster	12020	12784	12080

Patient safety incidents resulting in severe harm	April 2014 to Sept 2014	Oct 2014 to Mar 2015	April 2015 to Sept 2015
ELHT number reported	29	28	18
ELHT % of incidents	0.4	0.4	0.3
Cluster average number	15.5	17.3	15
Cluster average reporting rate	0.9	0.4	0.4
Minimum value for cluster	0	1	1
Maximum value for cluster	74	128	89
Total incidents across cluster	2168	2373	2052
Cluster % of incidents	0.4	0.4	0.3

Patient safety incidents resulting in death	April 2014 to Sept 2014	Oct 2014 to Mar 2015	April 2015 to Sept 2015
ELHT number reported	3	6	8
ELHT % of incidents	0	0.1	0.1
Cluster average number	4.9	5.2	5
Cluster average reporting rate	0.2	0.1	0.1
Minimum value for cluster	0	0	0
Maximum value for cluster	27	24	22
Total incidents across cluster	683	716	665
Cluster % of incidents	0.1	0.1	0.1

East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

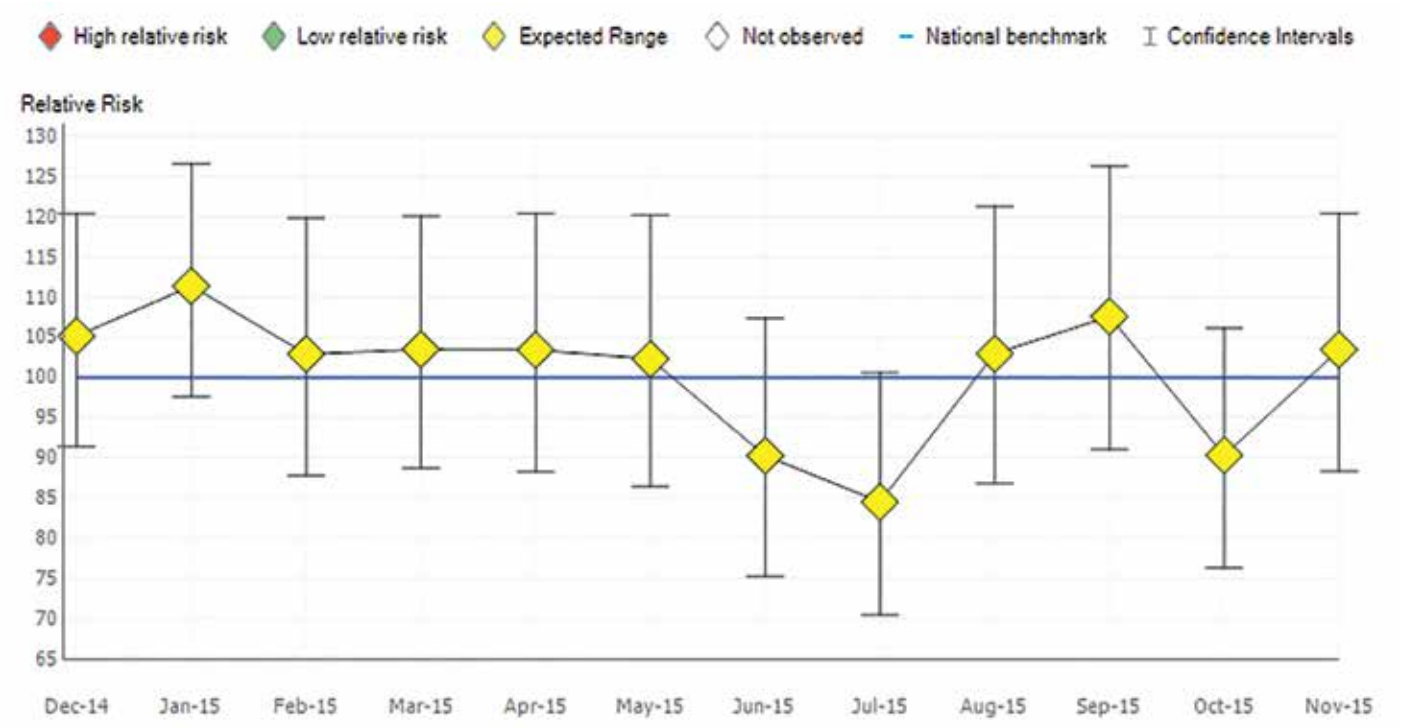
- The overall number of incidents reported by the Trust over the last three reporting periods has reduced gradually which demonstrates a reduction in harm caused to patients as a result of the Trust's comprehensive quality improvement / harm reduction programmes.
- The Trust does however consistently reports higher numbers of incidents compared with other similar Trusts in the cluster. This demonstrates an open and transparent culture within the Trust as incident reporting is positively encouraged. Significant work has been undertaken to ensure incident reporting is seen as a learning process and not one where staff are reprimanded or disciplined unless that is clearly indicated. This has been particularly evident with the introduction of the Serious Incident Requiring Investigation panel. The panel focuses on the identification of lessons learned and actions taken following its review of serious incident investigations to ensure services are improved and harms are reduced.
- The Trust is not an outlier in terms of the numbers of severe harms and deaths due to patient safety incident. Significant work has been undertaken to ensure accuracy of grading both at the time when an incident is reported and when the ensuing investigation is complete.
- East Lancashire Hospitals NHS Trust has undertaken the following actions to improve these
- rates and so the quality of its services:
- Further investment in root cause analysis training for incident investigators to ensure accurate and effective investigation outcomes
- Linking of the complaints process to the incidents process to ensure a combined approach to the investigation of harm
- Daily triage of all incidents that are reported to review the grading and to ensure an appropriate level of investigation.

3.3 Achievement Against Other Quality Indicators

Hospital Standardised Mortality Ratio (HSMR) (DFI Indicative)

The HSMR measures deaths in fifty six diagnosis groups which account for the majority of in hospital deaths. This is a risk adjusted measure which looks solely at deaths that occur in hospitals and takes palliative care and deprivation into account in the risk adjustment. Annual rates are published in the Dr Foster Guide each year.

The graph below sets out the Trust's HSMR performance from December 2014 to November 2015. The HSMR for this period is 100.40 (CI 96.63 – 105.35)



8 Steps to safety

A short film inspired by the airline safety industry has been developed to help our patient stay safe whilst in our hospitals. Based upon the concept of safety advice given on aircraft before take-off, patients are provided with an information card containing simple advice about a range of avoidable complications.

The film covers the following eight topics:

- Preventing falls
- Preventing blood clots
- Preventing infection
- Your medicines
- Pressure ulcers
- Identification
- Any concerns
- Leaving hospital

Designed as part of the inpatient welcome pack, the information card supports the Trust's commitment to patient safety and enables patients to play an active role in their care.

Urology robot - picture timbradleyphotography.com

Urology robot

Patients requiring surgery for prostate cancer at East Lancashire Hospitals NHS Trust are now benefitting from improved cancer outcomes by way of robotic assisted surgery at the Royal Blackburn Hospital.

The Urology Department commissioned the installation of the 'Da Vinci Robot' to carry out prostatectomies (removal of the prostate gland), a first for the Trust and the only Da Vinci robot used for urological surgery in Lancashire.

The Robot brings with it huge clinical benefits for patients with improved cancer outcomes as it gives the surgeon the opportunity to remove the prostate gland with a high degree of precision. This more precise cancer removal results in less pain, a shorter recovery period and hospital stay as the surgery is far less invasive; less requirement for radiotherapy; improved long term outcomes for continence and potency and a quicker return to normal activities.

The robot will initially be used within urology cancer surgery but also has the ability to work within gynaecology, colorectal and hepatobiliary surgery.

The national incidence of prostate cancer has tripled over the past 40 years and continues to rise with 315 patients in East Lancashire diagnosed every year. This robot means that we are able to offer our patients state of the art surgery which will result in a more precise removal of cancer and a far quicker recovery period as the procedure is much less invasive.

Butterfly Serenity Suite

The Trust's Butterfly Serenity Suite provides a room for families who have suffered either a stillbirth, mid-trimester or late-trimester pregnancy loss, in which to give birth and spend time with their baby and extended family to say goodbye as service users and charities i.e. SANDS recommend enhanced facilities for this client group. Although the Trust already had a Serenity Suite for bereaved families, this was often in use and as such bereaved parents Mark and Joanne Edwards set about fundraising for a second suite. The couple worked tirelessly with Trust staff to create and furnish the second Suite which was previously a standard birth room that has been re-designed with input from service users in order that it better meets the needs of the mother, partner and extended family at this time. The facilities are self-contained including bedroom with double bed, en suite bathroom, sitting area and kitchen area .Miscarriage keepsakes and memory boxes are available for bereaved parents

Patient Led Assessment of the Care Environment (PLACE)

The Trust has been awarded excellent marks for standards of cleanliness, condition, appearance and maintenance as well as privacy and dignity in the Patient-led Assessment of the Care Environment (PLACE) report.

The Trust's overall cleanliness rating rose to 96.47%, a significant increase on the previous year's score of 91.68%.

East Lancashire Hospital's PLACE rating also saw increases in Condition, Appearance and Maintenance (90.43%) and Dementia Friendly, which scored 85.07% compared to national average of 74.51%.

PLACE assessments take place across the country and see local people go into hospitals to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance.

Flu vaccinations

Staff at the Trust have shown their commitment to patient safety with over 83% of them receiving flu vaccinations giving the Trust its highest uptake rate ever and placing it as one of the top Acute Trusts in the country.

Learning from mistakes

The Trust has been rated 'good' for its openness and honesty in the first national 'Learning from Mistakes League' published by the Department of Health.

The 'Learning from Mistakes League' ranks 230 NHS Trusts up and down the country against three 'key findings':–

- Fairness and effectiveness of procedures for reporting errors, near misses and incidents,
- Staff confidence and security in reporting unsafe clinical practice, and
- Percentage of staff able to contribute towards improvements at work.

Based on anonymous data gathered from the 2015 NHS Staff Survey and the National Reporting and Learning System, the Trust was considered to have 'good' levels of both openness and transparency.

Initiatives to embed a culture of honesty and openness throughout the Trust include departments holding regular 'Share to Care' meetings to determine where improvements can be made; publishing the regular 'Share to Care' bulletin and distributing it to all staff so they can learn from each other.

ELHT is also signed up to the Royal College of Nursing's 'Speak Up Safely' campaign and was one of the first Trusts in the country to appoint a staff guardian who personally supports and protects staff who raise concerns.

In addition, the Trust voluntarily publishes its 'Open and Honest Care' report each month, publishing data relating to patient falls, pressure ulcers, hospital acquired infections and rating it receives from the NHS Friends and Family Test.

Radiology Communication of Urgent Unexpected Findings

2015 saw commencement of the roll out of an additional feature to support clinicians in acting upon urgent unexpected Radiological findings. As well as reports being faxed and backup phone calls being made reports are communicated directly to a nominated e-mail address for Consultants where the alert can be picked up instantly. The purpose of this is to reduce the likeliness of results not being acted upon and subsequent delays in patient management.

This is in the process of being rolled out to all clinical areas and is being customised to the needs of each service.

Radiology Flow Coordinator

The Radiology department introduced a Flow Coordinator role to support with inpatient imaging requests. The department receives a vast number of imaging requests for all modalities on a daily basis which sometimes far exceeds the capacity available to accommodate them. The flow coordinator liaises with all wards to support with the prioritisation of patients and discharge of those who can safely go home and return for their imaging examination as an outpatient. This role supports in minimising delays in the patient pathway and timely discharge and onward management.

Breast Screening – Radiology

The Breast Imaging service at Burnley General Hospital successfully secured commitment from imaging giant Fuji Medical Systems to provide a state of the art Tomosynthesis Mammography Unit which will assist in identification and categorisation of very small breast lesions which may otherwise have not been identified until a later stage. Use of this technique may not only reduce the need for patients to undergo further imaging but can promote earlier detection or exclusion and potentially reduce the need for unnecessary invasive biopsy as categorisation of lesions will be easier. Installation of the system commenced in May 2016 and the unit is due to be operational by the end of June.

Midwife Sonographer

Midwife Sonographer

The Midwife-led Sonographer service is an innovative new service that aims to detect foetal growth restriction in mums-to-be and reduce stillbirths. The service is run by midwife, Julie Dimbleby, whose role it is to scan mums-to-be who are referred by community midwives following growth concerns when their baby is measured at antenatal appointments. The women are referred directly to Julie without having to wait for a departmental ultrasound scan appointment.

Midwife Julie and Antenatal Clinic Manager, Caroline Broome, have been the driving force behind the new service which was the result of a year of training for Julie at Birmingham City University in 'Third Trimester Foetal Surveillance' and clinical practice within the department. Upon completion of her training the Friends of Serenity charity kindly contributed over £1000 to the sonographer service.

Previously, women identified with growth concerns in the community setting would have to wait for a departmental ultrasound scan appointment with a sonographer; the midwife sonographer service ensures the women are seen within 72 hours, with 35 slots available each week. This service is of huge benefit to the women in East Lancashire and is unique in the local area and ensures that all women receive the best possible antenatal care. Julie has also been approached by a number of other Trusts keen to find out more about how the service operates and the expected results.

Falls Response Service

The Falls Response Service (FRS) is a collaboration between East Lancashire Hospitals NHS Trust & North West Ambulance Service. It has prevented patients from being conveyed and/or admitted to hospital after a 999/111 call when it is medically safe for them to remain at home. FRS visits in an unmarked car the paramedic carries out an initial assessment to determine initially if the patient is medically stable, if this is the case, the occupational therapist and paramedic work closely together utilising their combined skills and knowledge to develop a treatment plan to support the individual to remain at home.

- 78% (505) people seen by the service in a 12-month period have remained at home (this was based on an average of 3 days per week)
- Length of time from 999 call to FRS being on scene has reduced considerable from on average 2 hours for a PES to 20 minutes reducing the consequences of long-lies

Falls Response Servce

- Prior to the service 70% of patients who fall into this group would have been conveyed to hospital; now 70% of the patients seen by the FRS are remaining at home resulting in financial savings associated with Conveyance, Accident and Emergency Tariffs and HRG Tariff for a short hospital stays
- Effective intervention - with only 6% of patients seen by FRS following a fall were seen again within a week due to another falls incident.

Rheumatology Occupational Therapy

A major focus on self-management education with supported self-care and self-management was identified by the Department of Health for 70-80% of people with long term conditions.

Patients who are diagnosed with Inflammatory Arthritis are given the opportunity to attend the Inflammatory Arthritis MDT Education Group that is run by the Rheumatology Occupational Therapist and Physiotherapist. It is a great opportunity for patients and their family and friends to meet the members of the MDT, learn about their condition and also understand more regarding self-management.

There is also the 'Osteoarthritis of the Hand' education session which highlights the importance of self-management and corresponds to the recent publication of the OA quality standard. People are able to self-refer into the group and excellent feedback has been received by all those who attend.

A Rheumatology °ccupational Therapy service review has been completed since the groups were started highlighting an increase in referrals into the service and also a reduced number of first to follow-up appointments. An audit is to be completed which is intended to investigate if patients as a result of attending the group were satisfied with the knowledge gained and have confidence in managing their own condition.

1-1 Care Project (Creating a partnership in care)

At East Lancashire Hospitals NHS Trust, we put patients at the heart of everything we do and strive to improve quality and increase value. The 1-1 care project focuses on creating a "partnership in care" for vulnerable patients who might be at risk of harm or due to psychological needs need someone to stay with them at specified times. As part of this improvement project we aim to:

- Engage more with those who receive 1-1 care to improve their experience and keep them stimulated

- Engage more with family and carers to build a partnership with them and recognise their rights as care givers
- Create a standard process for determining which patients require 1-1 care and assessing this requirement every 24 hours
- To create guidance to determine different levels of enhanced care and what supportive interventions should be provided
- Strengthen how we communicate to family and carers especially in terms of understanding how the patient is in their home setting, what their likes/dislikes are and what information might be useful to us
- Over recent months, the cost of bank and agency staff for 1-1 care has rapidly increased across many organisations. By focusing on providing high quality services and improving experience, this should naturally have a positive effect on cost saving.

The project has been taking place on three pilot wards and demonstrated a 68% reduction in bank and agency spend, as well as an increase in patient satisfaction. The changes are currently being spread across all inpatient ward areas.

Speech and language quality improvements

- In conjunction with Catering and Dietetics, the new national diet textures and descriptors have been implemented across ELHT in-patient services to ensure the food offered to patients with dysphagia complies with national guidance. In addition a new fluid thickener product (Nutilis Clear) has been introduced across ELHT wards.
- The service for people using a surgical voice restoration prosthesis (SVR) post-laryngectomy continues to develop to promote opportunities for patient's self-management and to ensure a robust pathway from initial puncture through to long term survivorship and care. The service has been complemented externally for its up to date techniques and service design.

Physiotherapy quality improvement

Physiotherapy has been heavily involved in the creation of the Integrated Discharge Service, Intensive Home Support Service and the Integrated Neighbourhood Teams constantly looking at ways we can improve Clinical flow by achieving Safe, Personal and Effective Transfer of Care into the Community.

3.4 Statements from Stakeholders

Statement from Healthwatch Lancashire

What do you like about the 2015/16 Quality Account?
In layout, length and clarity, the Account is a model. It is especially encouraging to note the Trust's firm commitment to working in partnership and its intention to play its part in the vital work of Healthier Lancashire.

We would like to thank and congratulate the Trust for all the work of its directors, clinicians, nurses and ancillary staff. Our strong impression, from conversations with patients, is that the Trust is providing an excellent service to its community, even as financial and staff recruitment pressures increase.

What do you not like about the 2015/16 Quality Accounts?
It is surprising, especially given the somewhat peremptory tone of the covering letter about the need for stakeholders to respond by a deadline, that the Account has several, and important, gaps which still need to be completed. We appreciate that this is a draft, and that you will be inserting stakeholder and other responses in due course. Is it possible for us, then, to comment on the final draft?

What suggestions do you have for additional content for 2015/16?
For stakeholders who are not entirely familiar with the technical language and statistics which necessarily feature in the Account, 'less' would be 'more'. So we would not wish so much to add content as to request an executive summary, which would highlight key issues in plain language. Of course we understand that the Account has to contain details for NHS Improvement, and other technical audiences, but there is a danger that consultation with stakeholders could become almost meaningless in certain areas of the document.

What other comments or suggestions for improvements would you like to propose?
Although we understand that the Friends and Family Test is a tool required by the NHS, our observation is that whilst response leaflets are made available at key points in Trust premises, it is entirely up to the individual whether they fill them in. (We apologise in advance if we do not have a full picture of the way in which the tool is used). This raises a question about how valuable, comprehensive and objective the tool is as a measure of patient satisfaction, and implies that a better tool might be needed.

In this context, we are surprised that the report does not at any point refer to the work that the Healthwatchs of Lancashire and Blackburn with Darwen have jointly undertaken in talking to patients and families in hospitals. This is in spite of the fact that we understand this work was useful in helping to make the case for the construction of the 'final piece of the jigsaw' at Burnley General Hospital.

Whilst Healthwatch Lancashire will always aim to be supportive and constructive, we believe that an independent view of aspects of the Trust's work is likely to be more powerful than self-assessment.

Although 'patient stories' are an excellent way of understanding how it feels to the treated and not just the treater, it must be impossible at Board level to listen to sufficient stories to paint a comprehensive picture. There may even be a tendency to select for presentation only those stories which show the Trust in the best possible light!

Healthwatch Lancashire has developed a 'care circle' approach, where several patients/service users share their experiences without the presence of staff, which we believe provides a more objective approach.

What would you suggest are the Trust's priorities for quality improvements for 2015/16?
We would urge the Trust to maintain and develop in practical ways its contribution to Healthier Lancashire and the Transformation and Sustainability Plan for Lancashire and South Cumbria as the best way to improve outcomes for patients in the context of tight resources via 'whole system' change.

Do you consider that the draft document contains accurate information in relation to NHS services provided by the provider?
We can only assume that this is the case.

Do you consider that any other information should be included relevant to the quality of NHS services provided by the provider?
We are surprised that the statistics on pages 19-22 appear to indicate declining performance /satisfaction in some areas, and feel that explanatory notes here would be helpful. Without wishing to increase the size of the document unduly, we wonder whether much of this information could be summarized at the start, with statistics and their interpretation forming the 'technical' …..though vital for some readers….. appendix. We appreciate, however, that the Trust may not be free to re-shape the report in such a manner.

Statement from East Lancashire Clinical Commissioning Group

East Lancashire Clinical Commissioning Group (EL CCG) welcomes the opportunity to comment on the 2015/16 Quality Account for East Lancashire Hospitals NHS Trust (ELHT).

The Quality Account provides a detailed report of the Trusts achievements and challenges and sets clear priorities for 2015/16.

ELHT has demonstrated its continued commitment in 2015/16 to making improvements to quality and safety with a clear focus on delivering safe, personal and effective care. Throughout 2015/16 the CCG has worked closely with the Trust on the quality agenda with engagement through weekly teleconferences and monthly Quality Review Meetings.

Within the 2014-15 Quality Account the Trust identified three quality improvement priorities for 2015- 16:

1. Reducing the risk of malnutrition and dehydration - the Trust has worked hard to establish an electronic tool for the recording of nutrition and hydration. Progress has been monitored by the CCG through Quality Review Meetings. The CCG have been pleased to see the launch of the Food and Drink Strategy which will further improve and promote the importance of food in hospitals for patients, staff and visitors.
2. Increase compliance with the sepsis care bundle - the Trust has been part of Advancing Quality for sepsis and has been consistently one of the highest performing Trusts within this programme. Joint work on sepsis awareness has taken place via a sepsis event held in October 2015.
3. Reduce medication incidents that cause moderate harm - the Trust has not reported any medication errors causing serious harm in 2015/16.

ELHT has achieved 16 of the 25 national quality indicators included in their contract.

Pressures seen nationally within emergency care with unprecedented levels of attendance have impacted on A&E performance and ambulance handover rates.

ELHT had a challenging target for reduction in Clostridium Difficile infections in 2015/16 and recorded 29 cases against a trajectory of 28, an improvement on the previous year (32). The Trust continues to perform well against the National Rate and remains one of the better performing ordinary acute trusts. ELHT has been set a trajectory of 28 cases for 2016/17 and the CCG will continue to work with the Trust on post infection reviews in order to learn lessons that can be shared across the Health Economy.

MRSA had a zero tolerance target for 2015/16. ELHT reported a single case; the post infection review panel acknowledged there were no lapses in care.

The Trust has performed well against cancer waiting time targets with all targets being met at both Trust and EL/BwD CCG levels. The CCG will continue to work with ELHT on pathway redesign and the implementation of NICE guidance in 2016/17.

ELHT has performed well against the requirements of the 2015/16 CQUIN scheme with full achievement of 10 of the 12 indicators and partial achievement of the remaining two. The CCG acknowledge the hard work and dedication in this achievement and look forward to working with the Trust to continue to improve quality through the 2016/17 scheme.

The Trust has shown commitment to improving complaints processes in 2015/16. It is encouraging to see the reduction in the number of formal complaints that have been made and the focus on resolving concerns as they arise.

ELHT remains a high reporter of incidents; organisations that report more incidents usually have a better and more effective safety culture. The CCG has noted improvements in the quality of root cause analysis investigation in 2015/16 through increased training and support to staff in incident management. This allows identification of lessons learned and the CCG has seen evidence of cascade of these via 'Share to Care' and from discussions with staff members as part of planned walkaround visits.

Inpatient survey results are encouraging and demonstrate continued improvement in patient experience across a number of measures. The Trust continues to have a high response rate for the Friends and Family Test (FFT) survey with a majority of patients who would recommend services.

ELHT has participated in 88% of National Clinical Audits and 100% of National Confidential Enquiries and this is a clear indication of an organisation with a commitment to delivery of evidence based safe care.

Data quality assurance remains high with compliance being maintained in recording of a valid NHS number and General Medical Practice Code. Clinical coding supports clinical care, treatment and outcomes and is directly linked to payment and costs.

The CCG is pleased to see improvements to Information Governance Toolkit compliance, with the Trust graded as 'satisfactory' and hope to see further improvements throughout 2016/17.

EL CCG support the priorities put forward for 2016/17 and look forward to working with the Trust to improve quality in these areas.

3.5 Statement of Directors' Responsibilities

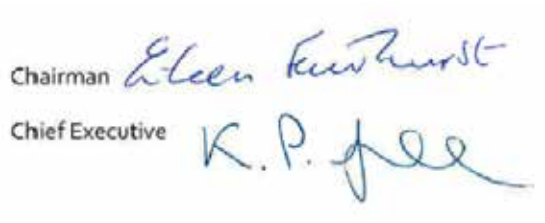
The Directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

Signed By Order of the Board:



Date: 1st June 2016

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GLOSSARY

Term	Explanation
Advancing Quality (AQ)	A process to standardise and improve the quality of healthcare provided in NHS hospitals
Antimicrobial	An agent that kills microorganisms or inhibits their growth
Care bundle	A group of interventions which are proven to treat a particular conditions
Care Quality Commission (CQC)	The independent regulator for health and social care in England
Clinical Audit	A quality improvement process that seeks to improve patient care and outcomes by measuring the quality of care and services against agreed standards and making improvements where necessary
Clinical research	A process that determines the safety and effectiveness of medications, devices, diagnostic products and treatment
Clostridium Difficile Infection (CDI)	A type of infection
Commissioning for Quality and Innovation (CQUIN)	A payment framework linking a proportion of a Trusts income to the achievement of quality improvement goals
COPD	Chronic Obstructive Pulmonary Disease - This is the name used to describe a number of conditions including emphysema and chronic bronchitis.
Datix	An electronic system that supports the management of risk and patient safety incidents
Dr Foster guide	A national report that provides data on patient outcomes in hospitals in the UK
Hospital Episode statistics	A data warehouse containing records of all patients admitted to NHS hospitals in England
Hospital Standardised Mortality Ratio (HSMR)	A national indicator that compares the actual number of deaths against the expected number of deaths occurring within hospitals
Indicator	A measure that determines whether a goal or an element of a goal has been achieved
Information governance toolkit	An online tool that enables NHS organisations to measure their performance against information governance requirements
Integrated Care group	An amalgamation of the medical and community services functions within East Lancashire NHS Trust
Monitor	A health service regulator within the NHS in England
Morbidity	The disease state of an individual, or the incidence of illness in a population
Mortality	The state of being mortal, or the incidence of death (number of deaths) in a population
MRSA bacteraemia	A type of infection
National Confidential Enquiries	A process to detect areas of deficiency in clinical practice and devise recommendations to resolve them
National Reporting and Learning System (NRLS)	A national electronic system to record incidents that occur in NHS Trusts in England
National Early Warning Scores (NEWS)	A tool to standardise the assessment of acute-illness severity in the NHS
NHS England	A body that oversees the budget, planning, delivery and day-to-day operation of the NHS in England set out in the Health and Social Care Act 2012
NHS number	A twelve digit number that is unique to an individual and can be used to track NHS patients between NHS organisations

Term	Explanation
NICE Quality Standards	A concise set of prioritised statements designed to drive measurable quality improvements within a particular area
Palliative care	When there is no cure for an illness, palliative care tries to make the end of a person's life as comfortable as possible.
Parliamentary and Health Service Ombudsman	A body that investigates complaints where individuals perceive they have been treated unfairly or have received poor service from government departments, other public organisations and the NHS in England
Patient Administration System (PAS)	A system used by acute trusts to electronically record patient information eg contact details, appointments, admissions
Patient Advice and Liaison Service (PALs)	A service that offers confidential advice, support and information on health-related matters
Payment by results	A form of financing that makes payments contingent on the independent verification of results
PDSA	Plan, Do, Study Act methodology for quality improvement
Pressure ulcer	Sores that develop from sustained pressure on a particular part of the body
Research ethics committee	A committee that approves medical research involving people in the UK, whether in the NHS or the private sector
Risk summit	A meeting of relevant agencies to address an issue of serious concern
Safety express	A national improvement programme to facilitate the delivery of harm free care to patients
Safety Thermometer	A local improvement tool for measuring, monitoring and analysing patient harms and harm free care
Secondary uses service	A national NHS database of activity in Trusts, used for performance monitoring, reconciliation and payments
Share 2 Care	A process to facilitate sharing of best practice and lessons learned
Summary Hospital level Mortality Indicator (SHMI)	The ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die
Strategic Executive Information System (STEIS)	An information management system utilised to performance manage serious untoward incident investigations
Trust Development Authority (TDA)	A body which is responsible for providing leadership and support to the non-Foundation Trust sector of NHS providers
Venous thromboembolism (VTE)	A blood clot forming within a vein

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East Lancashire Hospitals NHS
NHS Trust

This document is available in a variety of formats and languages.

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